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VOLUME XXXI
NUMBER 1

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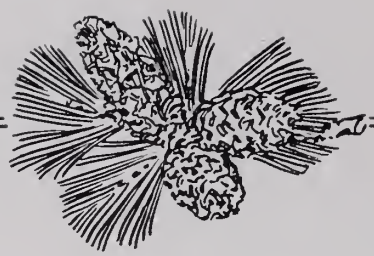

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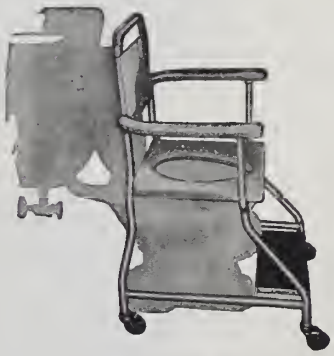

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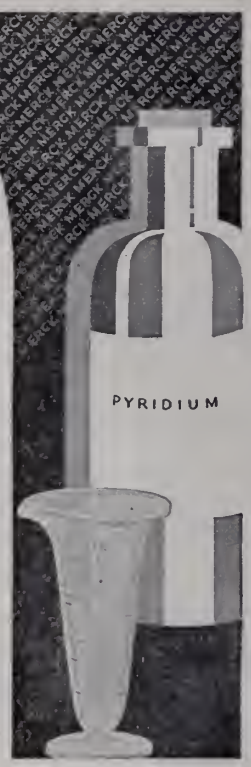

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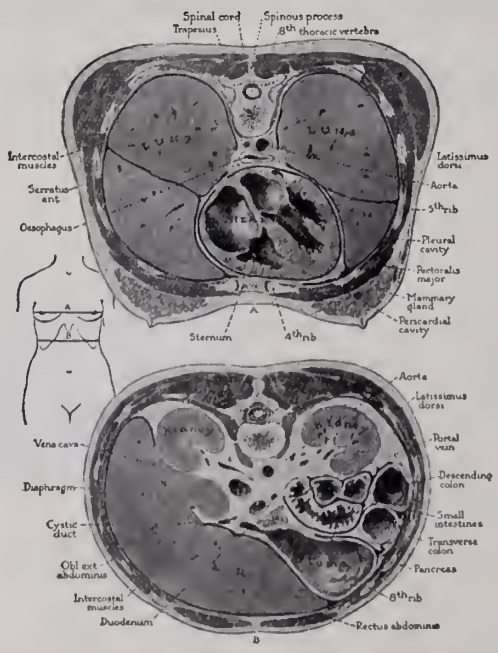

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The Wisconsin Medical Journal

Volume XXXI JANUARY, 1932 No. 1

Acute Mastoiditis; Comparison of Operative and X-Ray Findings*

By HENRY B. HITZ, M. D.
Milwaukee

The literature on mastoiditis is prolific, filled with valuable material that has been rapidly accumulating for the past fifty years. The time, however, allotted to me does not permit even of a cursory survey. The views here briefly presented are based upon a broad personal experience and are intended primarily to emphasize certain factors that seem to be too frequently ignored.

Acute mastoiditis may be a serious calamity, or an event of minor significance, depending entirely upon its early recognition and prompt and proper care. Too often the otologist is called upon to see and care for cases in the third and fourth week of the disease; then only when immediate operation has become necessary, and because of needless delay, with the still further possibility of meeting with serious complications.

A copiously discharging middle ear with mastoid involvement may show very mild symptomatology, while the reverse may show severe pain, high temperature, and marked leukocytosis. Yet the character of the bony capsule may be such that the destruction and severity of the disease may be far greater and more rapid in the former type of case than in the latter.

Acute mastoiditis may be said to terminate in one of four ways.

First: Though rarely, spontaneous recovery may occur without complications.

Second: By partial recovery, with the subsidence of acute symptoms leaving a chronic suppuration of the ear, with serious injury to future hearing and with always the later menace of intra-cranial complications or future, more radical operation. (Chronic suppuration of the middle ear may be looked upon as a monument to undiagnosed and unoperated acute mastoiditis.)

Third: By prompt and thorough operative measures, leading to a rapid return to normal health, with little or no loss of hearing.

Fourth: By death from one of the many complications possible, viz: meningitis, brain abscess, sinus thrombosis, septicemia, etc.

CAUSES

The most frequent, apparent, individual cause of acute middle ear infections, consequently of acute mastoiditis, is direct extension through the Eustachian tube from the throat in the course of acute infections of the upper air tract. Of the many etiological factors, influenza is by far the most frequent infecting element. There is a reason for this which does not seem to be generally appreciated. Beginning as influenza generally does (Carl Seilers "Epidemic Subglottic Oedema)", as a subglottic process causing a spasmodic cough, inflammation of the mucous membrane spreads, not unlike the invasion of erysipelas (or like the widening circles created by dropping a stone into smooth water) and extending outward to the terminal filaments of mucous membrane. With this invasive process go superimposed some of the various organisms of destruction, and by its devitalizing effect rendering these tissues susceptible to this additional and disentegrating influence. These superimposed deleterious elements are mainly comprised within the staphylococcus, streptococcus, and pneumococcus groups. In many cases, except by the sequence of events, differentiation may be difficult. In some instances, however, the patient may pass for a short period through a distinctly non-pyogenic infection as evidenced by a subnormal temper-

* Presented before 90th Anniversary Meeting, State Medical Society of Wisconsin, Madison, Sept. 1931.

ature and leukopenia, with an acute catarrhal process, the nasal discharges being of an egg white mucoid character, later suddenly becoming more copious and markedly purulent with an entire change of clinical picture, i. e., a marked degree of fever and pronounced leukocytosis. The constant, violent nose blowing under those conditions further tends to carry the infectious process into the ears and adjoining mastoid structures. Scarlet fever, measles and diphtheria, while all too frequent causes, are definitely less common factors than is influenza. With the steadily increasing control of these diseases they must eventually become of minor importance.

IMMEDIATE AND REMOTE DANGERS

Acute inflammatory involvement of the middle ear and adjacent mastoid structure is fraught with certain dangers, often associated with much physical discomfort, depending somewhat upon the type and virulence of the infecting organism. Aside from the intense earache quickly relieved by prompt incision of the drum, the extension backward into the cellular structure of the mastoid carries with it the potential possibility of invasion of the petrous portion of the temporal bone or extension into the cranial cavity. Oftentimes the violence of this mastoid invasion rapidly produces a bursting charge of highly infectious material which must of necessity find its outlet along the line of least resistance. The infinite varieties of structure and the degrees of density of bone material are factors which, even with good x-ray plates, it is often impossible to know.

The developing pressure finds its outlet either directly through the weakened bone structure, by blood stream, or lymphatics, hence the complications of labyrinthitis, sinus thrombosis, perisinus or epidural abscess, temporo-sphenoidal and cerebellar abscess, or meningitis. This last, if of the fulminating type, is certainly the most to be feared.

Delay in promptly meeting the indicated measures at an early period in the process is one of the prime sources of these complications, as is also the failure to thoroughly complete operative procedures when once begun. One hears altogether too frequently of a recently operated mastoid having to be reopened. The re-opening of a half healed mastoid wound in my opinion implies poor or incomplete primary work or bad surgical technique and judgment in the proper after care. The necessity for early recognition of acute mastoid disease is paramount. Far too often because of the abeyance of alarming symptoms and the failure to appreciate early the possibilities, haphazard care or futile treatment is given in these cases until menacing symptoms suddenly loom up. Then the otologist is called upon in a hurry to handle a badly complicated, dangerous situation which might otherwise easily have been avoided.

EARLY SYMPTOMS

What then are the dependable early symptoms and signs of acute mastoiditis? Disregarding the classical symptoms which, in my judgment, are generally late manifestations of the disease. In the order of their importance I should say:

First: In the presence of an acutely suppurating middle ear, *pain* and *tenderness* on deep pressure over the mastoid tip, Macewen's triangle, or possibly over the zygomatic root.

Second: Copious serosanguinolent or purulent discharge from the external auditory canal, without much pain or marked tenderness over the mastoid, on the theory that a "quart of fluid *cannot* be obtained from a pint measure". A large quantity of discharge coming from an external auditory meatus must of necessity come from elsewhere than the small space of the middle ear, with its most probable source in the adjoining mastoid.

Third: X-ray plates taken in the proper position whenever possible. Regardless of the pathological finding, properly taken x-ray plates give a clear cut view of the structure of the mastoids, the extent of the cellular development and often of the relative position of the sigmoid sinus. The variability of the cellular structure in definite cases is so great and so common that it is of the utmost importance to be informed of what

may have to be dealt with, before operating. It is often the lack of this information that has resulted in so many poorly done mastoids and one of the large factors in making necessary secondary operative procedures.

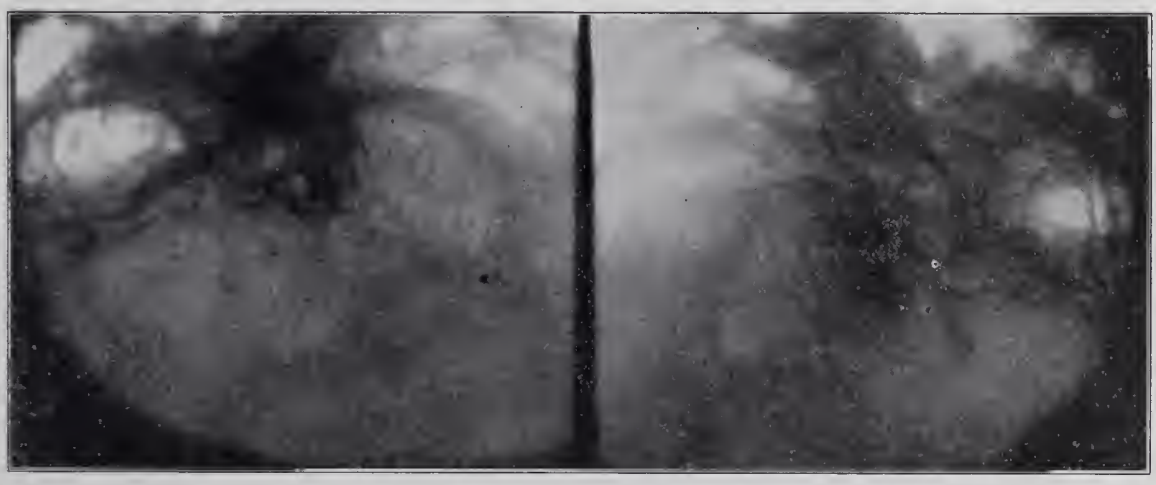
From a pathological standpoint good x-ray plates may be tremendously helpful, especially when one ear is normal and the other the seat of inflammation. In the case of the normal mastoid, the cells, few or many, usually show up with clean cut trabeculae. On the other hand in the diseased case there is usually a general blurring with often a complete absence of visible trabeculae. It may be as well to say here that no x-ray plate of the mastoid, regardless of how much abnormality seems apparent, is alone sufficient justification for submitting a patient to operation. If, however, other clinical factors of acute middle ear disease *are* present and, if there has been the history of recent pain or tenderness over the mastoid apophysis, coupled with a purulent discharge from the middle ear, there is a factor of much value in the x-ray findings. These also in association with the presence of a leukocytosis of some degree, fever, with other possible etiological factors excluded, are sufficient justification for operative measures.

Fourth: Fever which may be more pronounced before the drum has been incised than later, is never entirely dependable as it is more often the result of the original infection than of the local ear manifestation. Many severely destructive acute infections of the mastoids show but little abnormal temperature. This is particularly true where the discharge from the external ear is copious and where the amount of pain is relatively small.

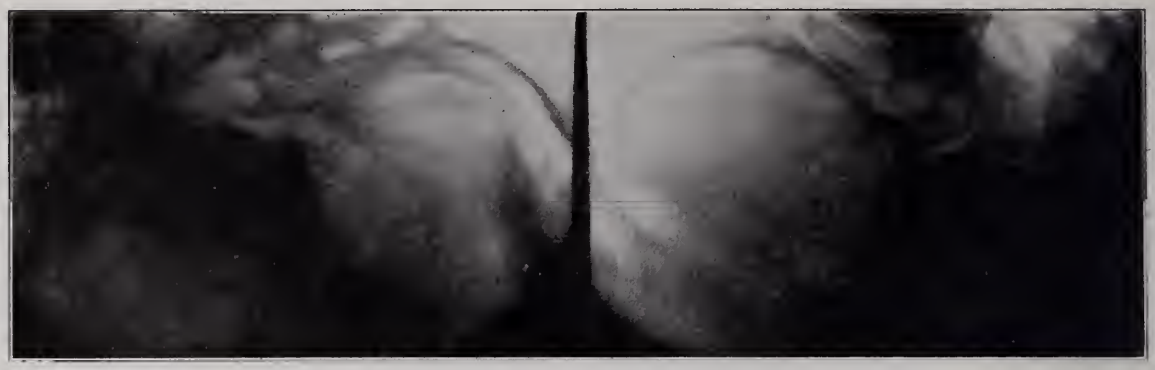
Fifth: Blood. A leukocyte count should always be made, not once but a number of times if feasible. When possible a complete blood study should also be done partly for the record, but also to definitely exclude other possible acute inflammatory processes and, when necessary, blood cultures and spinal fluid examination.

Sixth: There should always be a careful general physical examination recorded.

A comparison of the clinical findings with the roentgenology would seem to be a better method of demonstrating the value of the x-ray as an aid to diagnosis and an additional aid to thorough operation. During the reading of this paper I shall throw on the screen a series of plates taken early in the past winter, all practically speak for themselves and each plate is accompanied by a resumé of the clinical findings taken from the charts of the subsequent operative measures. Attention is invited to plate No. 9 which shows an unusual and extraordinarily extensive cellular development in a girl of about fifteen. When operated the affected side was found to be completely shot through with separate foci of pus without, however, much breaking down of the intercellular trabeculae. Had operation been delayed or incomplete, it is easy to conceive of the prob-



9. Operation right. Note extensive cellular character. Fine cells, diploetic type. Antrum and scattered areas filled with pus. Gradenigo's syndrome. Streptococcus haemolyticus.



2. Operation right. Cortex thin. Bone diploetic. Shot through with pus from tip to zygoma. Epidural pocket at apex Macewen's triangle. Streptococci.

able complication which would have arisen. Recovery in this case was uneventful, although for two days immediately following the operation the patient showed evidence of a Gradenigo syndrome, with third and sixth nerve partial paralyses on the right side. This would seem to show that the extensive cellular development in this particular case extended also into the petrous portion to its inner extremity.

Attention is also invited to plate No. 2 in which a large separate cell at the apex of Macewen's triangle well back over the old masto-squamosal suture was diagnosed as a probable epidural pocket and definitely proven to be such, at the time of operation. This pocket, apparently separated from the rest of the mastoid concavity, contained fully a gram of thick, yellow pus with the bone over the dura absent.

When operation has been determined upon it should be promptly done and thoroughly executed. With the x-ray finding one should know before hand the extent of the bone investigation necessary. Too often there is a failure to investigate the cells of the zygomatic root and almost as frequently the cells at the apex of Macewen's triangle, along the line of the old masto-squamosal suture. Often failure to thoroughly eradicate the infected cells is the cause of prolonged recovery or of the complication of meningitis or brain abscess and far too often of the doing of an immediate secondary operation with all of its magnified dangers. In no other surgical field are half done measures more reprehensible than in the field of mastoid surgery.

As to the best time for operating, there are a number of diverse opinions. Some prefer to wait until nature has thrown out "her protective walls" or delineated the area involved. This may occasionally be a safe enough procedure, however, I have never been able to see sound reasoning in this method. The dangers of unnecessary delay have always been to me graver than the dangers of a properly done operation under favorable conditions. The writer and his associates have stood unequivocally for early operation, after first definitely determining the presence of a destructive process in the mastoid. It is yet to be shown that this judgment is in error. It is doubtless true that when operation has been delayed the clearing of the diseased bone is an easier matter; on the other hand there are much greater possibilities of the condition by reason of delay having already extended beyond the bounds of safety. It would also seem reasonable to expect more prompt and rapid healing if the bone tissues are not left to become thoroughly devitalized by prolonged inflammatory action.

CASE REPORTS

For the purpose of emphasizing the desirability of prompt and thorough operation, let me briefly cite several examples of fatal complications, the direct result of failure to recognize mastoid infection sufficiently early, to make the proper measures effective.

Case one: W. S. ill for three weeks with an acute cold in the head and discharging ears suddenly developed chills followed by fever of 105°-106° of short duration. After some delay otological advice was sought and

a diagnosis of bilateral mastoiditis with the probability of a septic sinus thrombosis was made. Both mastoids were promptly exenterated and the sigmoid sinuses uncovered. The right being definitely involved, was opened, a septic clot removed, and the internal jugular in the neck tied and resected. The left sigmoid was also exposed but appeared not to be positively involved. However, as the temperature of the type of a septic thrombosis continued to persist for some days, the left was re-examined and was also found to contain a septic clot. This child died in the fifteenth week of the disease. In discussing this case later with Dr. Kopetsky, he stated that in the study made of septic sigmoid sinus thrombosis for his test book, he had looked up the literature but could find no record of a case of bilateral sigmoid sinus thrombosis having survived more than six weeks.

Case two: Another and fatal instance of the failure to act promptly in a fulminating type of mastoiditis was the case of C. H., a prominent citizen, who, while apparently in excellent health, was seized with a severe pain in one ear followed by pronounced mastoid tenderness and discomfort. His physician was promptly called and incised the drum, releasing a copious discharge of serosanguineous character. On the fourth day he lapsed into unconsciousness and consultation was called. Immediate mastoid operation was advised. In an unconscious condition he was removed to the hospital, but while being carried into the operating room developed a severe convulsion. When placed on the table he was in an apparently dying condition. His family, being informed of the hopeless situation, insisted upon the operation being carried through. The mastoid was promptly opened and found to be extensively involved and the dura of the middle fossa laid bare by the disease, was dark and necrotic. When the bone around this area was removed, the dura ruptured discharging from a subdural pocket several ounces of thick pus. The patient did not regain consciousness and succumbed in one hour.

SUMMARY

To briefly recapitulate, the points it is desired to bring out clearly in this paper are as follows:

1. That acute mastoiditis is always potentially a serious matter from its inception and should be promptly recognized and efficiently handled.

2. That a general physical survey should always be made including x-ray of temporal bones, frequent eye ground examinations, blood count, and urine analysis and upon the slightest suspicion of complication, blood cultures and spinal fluid examination.

3. That operation when it has been decided upon should be promptly done and completely executed. Half done measures are worse than useless. Secondary operations may be considered to be evidence of poor primary work and of poor judgment. They greatly add to the danger to life and prolong the period of recovery. Over-long pre-operative observation also makes possible the subsequent danger to hearing, for the longer a discharge continues from a middle ear the more are inflammatory residues likely to be a disturbing element to future hearing.

4. That properly taken x-ray plates are invaluable in determining the extent of the cellular development and often the degree and possible extent of the infected area. They should always be taken whenever and wherever the means of so doing are available.

In conclusion it is, in the opinion of the writer, unfair to ask of a consultant a prompt decision as to possible complications, such, for example as a septic sinus thrombosis, until other possible sources of infection are ruled out, namely, other causes of positive blood findings, whether due to valvular heart or pyelitis, etc.; with also a properly recorded temperature chart, temperature being taken at two hour intervals for at least twenty-four hours, etc. However, with the full facts before one, diagnosis is as a rule not particularly difficult.

In choosing the title of this paper I have done so with the distinct hope of trying to clear up what appears to be a rather general misconception of this subject in the minds of many who have little contact with this line of work. I take this view because of

the frequency with which we are called in consultation to see cases in which mastoiditis has been suspected, when actually the case in question is really in the later stages and should long before have been opened. Too often are the "classical" symptoms of mastoiditis "late manifestations", and much damage may be done, both to subsequent hearing and to healing, to say nothing of the greater possibilities of serious, nay vital, complications arising by reason of needless delay in giving the patient the proper attention.

Clinical Aspects of Oxygen Want*

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During administration of anesthesia by inhalation, alveolar oxygen and carbon dioxide tension are directly under the control of the anesthetist. He is, therefore, in a particularly favorable position to observe the clinical effects of increases and decreases in the intake of oxygen.

The following list of signs and symptoms noted to follow moderate and extreme reductions in alveolar oxygen tension in various individuals undergoing surgery should be suggestive as to the cause of similar signs and symptoms observed to afflict patients in the medical wards.

SIGNS OF ACUTE EXTREME OXYGEN WANT

1. Pulse—slow, bounding, often arrhythmic or irregular.
2. Pupil dilated, fixed.
3. Respiration depressed or arrested.
4. Systolic pressure raised markedly until respiratory arrest.
5. Muscles convulsive.
6. Color cyanotic or ashen.

SIGNS AND SYMPTOMS OF MODERATE OXYGEN WANT

1. Mental disturbances, anxiety, restlessness, delirium.
2. Air hunger.
3. Precordial pain.
4. Vomiting or retching.
5. Muscle twitching, contraction of individual muscles or groups.
6. Pulse—increased rate; arrhythmia or irregularity in cardiacs.
7. Systolic pressure—often slight rise or fall.
8. Respiration: Any disturbance such as sighing, yawning, noisy, irregular or arrhythmic, periodic, prolonged expiratory phase, obstruction due to edema of tongue, spasm of larynx, etc.

Cyanosis accompanies the signs of moderate oxygen want in less than twenty-five percent of cases. Whenever any one of these signs or symptoms appear during operation, whether the patient is asleep or awake, the anesthetist is frequently able to reestablish the normal status by increasing the alveolar oxygen tension.

The chemist, in discussing his reactions, speaks of "available oxygen" to designate that portion present which is not strongly bound and may be readily used for recombination. It seems rational for physiology to borrow the term "available oxygen". Oxygen must come in contact with the cell through the blood plasma and tissue juices before it can become available for chemical or physiologic activity in the cell. Warburg maintains that the presence of an enzyme or hormone is necessary to activate the oxygen or transform it into "available oxygen" for the cell. Oxygen contained in the hemoglobin may be considered "unavailable" from the standpoint of its ability to support physiologic activity in the tissue cells of the various organs. The anesthetist frequently sees his patient in a condition of complete oxygen saturation as judged by color, that is, the hemoglobin is filled with a normal amount of oxygen, and yet an increase in the alveolar oxygen tension will eliminate one or more of the undesirable signs or symptoms listed

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above. Does this mean that by raising the oxygen concentration with which the blood comes in contact in the alveoli, he has increased the oxygen in solution in the blood plasma and so delivered more "available oxygen" to the cells? The clinical fact is observable. The physiologist must offer the explanation. On the other hand, the anesthetist often conducts an anesthesia, with nitrous oxide for instance, during which a distinct dusky cyanotic color is present and yet none of the signs or symptoms of moderate oxygen want appear. Temporary extreme increases of alveolar oxygen tension bring about no resulting improvement in the patient as judged by all the signs available other than color. Does this mean that "available oxygen" is plentiful, but the "unavailable oxygen" in the hemoglobin is deficient, resulting in a harmless cyanosis? In attempting to maintain normal physiologic activity in his patients, the anesthetist has come to require more than the absence of a "bad color" as assurance that his patient does not suffer from oxygen want. A pink patient is much less likely to be suffering from oxygen deficiency than a blue one, but the presence or absence of other physical signs and symptoms has served as a much better guide.

In anesthesia we have come to recognize that the signs and symptoms listed above may be caused by oxygen want and that they may usually be ameliorated by providing an increase in oxygen tension of the inspired atmosphere. Only those signs and symptoms which are quite uniformly relieved by increasing the percentage of oxygen inhaled have been included in the list. However, the anesthetist comes more and more to feel that whatever unphysiologic condition may develop during anesthesia, a trial of excess oxygen should be made as a possible remedy.

CAUSES OF OXYGEN WANT

The causes of oxygen want can be considered under four general headings: A. Respiratory deficiency, B. Circulatory deficiency, C. Biochemical deficiency, and D. Excess metabolic demands for oxygen.

A. RESPIRATORY. — Respiratory deficiency can be considered under three headings: I. Obstructions, II. Depressions, III. Paralyses. Respiratory obstruction can affect the upper respiratory tract, or it may affect the quantity of alveolar surface available for absorption.

I. Respiratory Obstructions. Upper Tract: The obstructions of the upper tract are either pathological or mechanical. Tumors, hypertrophies and edemas of either the upper respiratory mucosa or of surrounding structures may cause obstruction to the air passages. Numerous mechanical factors can interfere with the free passage of atmosphere to and from the alveolar surface. Foreign bodies most readily come to our mind as mechanical causes of obstruction, but many other conditions are quite as likely to cause obstruction and are more likely to be overlooked. The matter of position of the head in relation to the body; muscle relaxation, for instance the muscles of the tongue, pharynx, and the masseter muscles may permit of various anatomical changes in the relation of structures which will result in partial obstruction of respiration. Muscle spasm as well as relaxation can obstruct. Many patients in a weakened condition with some obtundation of their pharyngeal and laryngeal reflexes succumb to the respiratory obstruction resulting from the presence of vomitus, blood, mucous, fluid, etc. in the upper air passages. A partial obstruction from any one of these causes may be much more dangerous than a complete obstruction, since it is more likely to be overlooked, and probably a partial obstruction existing over a considerable period of time will more often result disastrously than will an acute complete obstruction which demands immediate relief by the help of physicians or nurses.

Alveolar Obstructions. Perhaps one does not always think of the word obstruction in connection with the alveolar surface, but we like to so consider the pathological obstructions of the alveolar surface as exemplified by pneumonia, tuberculosis, pulmonary abscesses, etc. Other pathological obstructions are edema, inhaled vomitus into the alveolar area, or tumors of the pulmonary tissue. Mechanical alveolar obstructions are exemplified by position. We are particularly apt to overlook the likelihood of decreas-

ing the alveolar surfaces by unreasonable positions. The anesthetist has long felt that the use, for instance, of a high kidney lift in the flank, to facilitate the removal of the kidney of the opposite side, has had an influence on the ability of the lung to take up anesthetic agents and oxygen by inhalation. More recently it has been clearly demonstrated by use of roentgenograms that a person, even when unanesthetized and with normal muscular tone, placed in the lateral position with a pad under the flank, may suffer compression of the lower lobe. Tight binders, plaster casts, etc., can have a similar effect in decreasing available alveolar surface. Constant maintenance of the prone position can likewise, to a considerable extent, decrease the absorptive surface available. Massive collapse of the lung is often promoted by unreasonable or too prolonged maintenance of these unfavorable positions. Mechanical interference with the alveolar surface may also be produced by compression from the growth of extra-pulmonary tumors, extreme distension of hollow viscera, etc.

II. Respiratory Depressions. The depressions of respiration constitute a vicious cycle since lack of oxygen resulting from an initial depression further depresses the respiratory center. The depressions in general may be divided into pathologic and pharmacologic.

1. Pathological. Among the pathologic causes of respiratory depression are increased intracranial pressure from brain lesions, muscle paralysis from central nerve lesions or from peripheral lesions, and chemical abnormalities of the body fluids.

2. Pharmacological. The pharmacologic causes of depression of respiration might be listed as the drugs which relieve pain—ether, opium, barbiturates, tribromethanol, etc. In addition, many other poisonous drugs result in depressing the activity of the respiratory center.

III. Paralyses. Partial paralyses resulting in decreased respiratory activity and secondary oxygen deprivation are not so rare as is commonly felt. Poliomyelitis may paralyze the intercostal muscles or even the diaphragm, resulting in extreme oxygen want, but we are prone to forget that ether and chloroform, as the dose is increased, likewise cause an ascending cord paralysis which first depresses then paralyzes the intercostal muscles and later the diaphragm. Many ether anesthesias are daily conducted in our hospitals accompanied by partial or complete intercostal paralysis. The derivatives of barbituric acid in sufficiently large doses, depress or paralyze intercostal activity. Tribromethanol and many other drugs may have a similar effect. Dosage is the important factor in avoiding such partial respiratory paralysis. Peripheral block anesthesia or block of the spinal motor roots, with locally acting drugs such as novocaine, may result, and usually does result, in some degree of intercostal depression or paralysis. No case of spinal anesthesia which causes a marked drop in blood pressure escapes a similar degree of intercostal muscle flaccidity.

B. CIRCULATORY. The circulatory causes of oxygen want can be divided into four main classes: I. Deficiency of cardiac output, II. Hemoglobin or red cell deficiency, III. Plasma deficiency, and IV. Vasomotor deficiency.

I. Cardiac Output Deficiency. The cardiac output may be decreased from muscular causes. The cardiac muscle may be in a state of degeneration, of fatigue, or of fibrillation. The intercostal muscles, as already suggested, may be either completely or partially paralyzed. The muscles of the chest, as they vary the intrapleural negative pressure, are of considerable aid in moving the blood stream. The cardiac output may, therefore, be definitely decreased as a result solely of intercostal inactivity. The valve leaks have long been recognized as causes of reduced cardiac output, but unnatural positions of the body are less frequently appreciated as causes of a similar embarrassment. Extreme sitting position for some patients and extreme Trendelenburg for other patients are serious embarrassments to the circulatory mechanism. When such extreme positions are long maintained in the presence of already disturbed physiology, their effect on the cardiac output, and therefore upon oxygen distribution, is definitely detrimental. Prolonged maintenance of the prone position is a frequent cause of reduced

cardiac output as well as reduced gaseous exchange in the lungs.

II. Hemoglobin Deficiency. The deficiencies of the hemoglobin are well recognized as included in the anemias, following hemorrhages and accompanying various drug poisonings.

III. Plasma Deficiency. The disturbances of plasma chemistry resulting in poor distribution of oxygen from hemoglobin to body cells have received little attention. Warburg's demonstration of a respiratory hormone in the cell, if verified by others, gives us a means of explaining why cell-oxygen want is possible in the presence of abundant oxygen in the hemoglobin of the blood. We know that the hydrogen-ion concentration of the blood plasma may seriously affect the transmission of oxygen from hemoglobin to cell. Carbon dioxide imbalance in the blood plasma not only affects the activity of the respiratory center directly, but affects the size of the capillary bed, and the dissociation curve for oxygen of the hemoglobin.

IV. Vasomotor Deficiency. The change in the size of the blood vessels throughout the body, due to disturbed vasomotor control, is well recognized as promoting or interfering with the delivery of well oxygenated blood to the tissues of the body.

C. BIOCHEMICAL. Biochemical deficiencies of the blood plasma and tissue juices, as well as of the cell structure itself, are influencing factors in controlling the ingress of oxygen to the cell substance. Acid-base balance disturbance is known definitely to interfere seriously with oxygen transfer. The likelihood of a disturbance or deficiency in the hormone of Warburg, and other little known factors as causes of cell-oxygen want, are still undetermined factors.

D. METABOLIC DISTURBANCES. The fourth group of causes of oxygen want were suggested as being metabolic in nature. In general there are four metabolic disturbances common in sick people which tend to result in increased oxygen demand and therefore in possible oxygen want in a given individual—namely, fever, fear, pain, and specific toxemia. We sometimes fail to remember that there is a seven percent increased demand for oxygen in the human body for each degree Fahrenheit rise in temperature above the normal. In the presence of fear, an individual is wont to utilize oxygen at an excessive rate. Pain with its various accompaniments demands a considerable increase in oxygen supply. Thyrotoxicosis is well recognized as a cause of increased oxygen demand. Syphilis and other infections are sometimes overlooked as the causes of a similar condition.

DISCUSSION

Factors which are known to be capable of causing oxygen deficiency in the cells of the body have been enumerated. One or more of these causes may be induced by the well meaning efforts of the clinician himself. Sometimes the relief of pain is impossible without accompanying interference with respiratory activity and oxygen want may follow as a consequence. In such a case, it is desirable that the tendency to oxygen deficiency be counterbalanced by corrective measures. Familiarity with the causes of oxygen deficiency should put the clinician in a position to eliminate these causes when physically possible. When removal of the cause is impossible, an effort may at least be made to correct the difficulty by the continuous or intermittent administration to the patient of oxygen enriched atmosphere.

By the very unscientific method of trial and error, the anesthetist has come to realize that many commonly occurring abnormal conditions seen in surgical patients before, during and after operation are due to oxygen want, and are relieved by increased oxygen tension in the inspired air. It is hoped that the present discussion may induce the clinician in general to try a similar method of experimental prophylaxis and therapy. The internist cannot always relieve respiratory obstruction by passing a metal or rubber airway into the pharynx or larynx, it is true, but he can, by adjusting the position of his patient, relieve a snoring ineffective type of air exchange. The surgeon can find some way of avoiding the positions which he finds convenient, but which are clearly inimical to satisfactory alveolar ventilation. Both surgeon and internist can use discre-

tion in dosage of depressant drugs. When evidence of oxygen-lack follows such administration, oxygen therapy is useful. Seldom does one see oxygen administered to the case of extreme acid-base balance disturbance, or to the individual suffering from loss of blood, or shock. Many of the possible causes of oxygen want listed above have never been subjected to a therapeutic test. If oxygen administration will relieve the signs and symptoms accompanying these conditions, even if the relief is temporary, the patient is the gainer.

The need for regulation of oxygen tension in the atmosphere of hospital wards is believed to be quite as essential for the physiologic good of many hospital patients as is the regulation of temperature and humidity. Until hospital architects and builders succeed in providing a sufficient number of beds with built-in equipment for oxygen tension control, the use of oxygen chambers, tents and the pharyngeal insufflation of oxygen must serve as unsatisfactory substitutes.

I wish to close, then, with a plea for attention to "oxygen deficiencies" as a possible accompaniment of the clinical conditions coming under your care. Remember that color of mucous membranes and skin (cyanosis) is variable, depending on individual characteristics and that at best, color is a criterion of the presence or absence of sufficient oxygen in the hemoglobin. Oxygen of oxyhemoglobin may or may not be "available oxygen". Availability to the tissue cells will depend on the presence or absence of normal chemical and biochemical balance in plasma, tissue juices, and cells. Remember that the tissues of patients suffering from fever, fear, pain, and toxemia are constantly demanding more oxygen than does normal tissue. Remember that many individuals normally exist in a state bordering on chronic cell-oxygen deficiency. Sedentary life leads to a low minute-volume respiratory exchange. Chronic carbon monoxide and other poisoning is prevalent. Acid-base imbalance is common. Such individuals, when disease overtakes them, are particularly susceptible to slight additional embarrassment of their respiratory exchange.

If everyday bedside therapeutics, by an understanding of the possibilities of cell-oxygen want and its avoidance, can come to benefit one-fourth as much as has the more specialized therapy of pain relief, the profession may lose some of its therapeutic nihilism.

What I Think About Cancer*

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It may be proper to state at the outset that what I have to say about cancer is not the result of personal research but is a selective resumé of what others have thought and done. Much of this already is known to one or the other of you. Nevertheless, I thought you may be interested to know what kind of a mental picture a physician of over forty years' practice may have formed of this very important, but as yet so little understood, disease. You may want to know, what, of all that has been written on the subject he has selected as conforming to his opinion and what he is willing to accept as possibly being true. You might want to know which theories about the cause of cancer fit in best with his own general views of life and death, with his knowledge of physiology, biology and pathology. Forty years of medical and surgical activity should have enabled him to crystallize his opinions on cancer and to solidify them into convictions, satisfactory to him for the present at least.

Thus, I am convinced that the incredibly large amount of work done on the causes and development of human cancer has so far been rewarded but meagerly and has resulted in but little practical value. That this should be the case, considering the enormous amount of time, means and diligence devoted to the task can only be understood on the assumption that many of the efforts have been applied in the wrong direction. The results of tumor research in animals have

* Presented before 90th Anniversary Meeting, State Medical Society of Wisconsin, Madison, 1931.

dominated too largely our views on the nature of human cancer and have with but slight reserve been accepted and applied to man. We know full well that the inoculable cancer of animals is entirely different from that of the non-transmittible human variety. Yet we have frequently applied to man theories and methods of treatment, that, though they cured animal cancer, were complete failures with us and disappointing in the results.

Again, we have accepted, what seemed to be a fundamental biologic fact, the statement that cells of every variety of tissue, including cancer cells, are able to reproduce their kind by automatic cell division. This has been found, by Bostroem and others, not to be true. The amoebic and the embryonic cell can reproduce themselves by simple division but that a muscle cell reproduces its kind, the bone cells reproduce other bone cells, epidermis epidermis, etc., is not true. The highly differentiated cells; i. e., those originally developed from the foetal embryonic cell and differentiated for a highly specialized function do not reproduce themselves but die when their life cycle is complete. The higher the cell is differentiated, the more its protoplasm is changed and organized for a special purpose, the more does it lose the other functions of protoplasm and amongst them the power of reproduction and regeneration. Generation and reproduction is only possible by a tissue that resembles the embryonic mesenchyme cells or tissue. This kind of tissue has been described by Eugen Bostroem. It is ever present and ever active and omnipotent as to the kind of cells it can produce. It is the mother cell of all differentiated cells. This post-foetal embryonic tissue in the form of enucleated protoplasm or syncytial cells, is found as an endothelial lining or reticulum in and about all capillaries and is present from birth to death wherever there are capillaries. It is the real organ of reproduction of tissues to replace old, worn-out cells, parts of destroyed organs or even whole organs, as often is the case in lower animals. Thus, it is the endothelial mesenchyme of the capillaries of muscles that will differentiate and reproduce muscle cells, when in the liver it generates liver cells, etc. These ever present, undifferentiated and omnipotent cells will, like embryonic cells, reproduce the kind of tissue in which they are located and to which they, so to say, are assigned. How could they develop into anything else but into the kind amongst which they are born and whose morphology and functions are forced upon them by food, locality and example!

The anatomical description of the endothelial mesenchyme harks back to and, perhaps, is similar to what has been described by Aschoff as the reticulo-endothelial system and with some modification the latter may be looked upon as a part of the former. It is the seat of normal growth, of post-foetal regeneration, of reparation and, I may as well say in advance, of tumor formation.

Eugen Bostroem of the University of Giessen, in his book "Der Krebs des Menschen" has described this endothelial mesenchyme, this capillary germinal tissue and after a morphogenetic study over many years is convinced that this tissue corresponds functionally to the embryonic mesenchyme of foetal life. All post-foetal cell reproduction arises from it, be it physiologic growth or pathologic tumors. Bostroem believes to have proved this without a question, and, if we also are convinced, we must discard the cancer theory of Cohnheim and Ribbert about the proliferation of a displaced hypothetical embryonic cell and also every other theory that has the conception of growth by cell division of the epithelium as its basis. Neither the normal epithelium, which is a differentiated cell, nor the cancer cell, which is also differentiated, are capable of division for the purpose of reproduction and growth. The normal epithelium and the epithelial cancer cell are both products of the post-foetal capillary endothelial mesenchyme and there are no essential morphologic or biologic differences between the two.

Normally, this endothelial mesenchyme is activated by nervous, endocrine or other influences (formative hormone) and the resulting activity is probably held in bounds by the same agents and ceases when the demand for normal growth and repair is satisfied and the local harmony of tissues has been reestablished. The process of generation of

the cells forming the carcinoma is not different from that of normal tissue and conforms to the same biologic laws. The difference being that in the case of cancer the activity of the endothelial mesenchyme is not held in check and limited, but owing to a systemic auto-intoxication or vice, is stimulated into continuous activity by a special endogenous agent. This endogenous factor Bostroem believes to be an autotoxin most likely formed in the gastro-intestinal tract and circulating in the blood stream. It is brought in contact with the endothelial mesenchyme and produces continuous stimulation and uncontrolled cell formation.

There is no such thing as a specific cancer cell, such as can be recognized singly by its structure. They are normal cells, but without function and because of that they are not especially vigorous. Contrary to the general belief they die sooner than the normal cells exercising a definite function, but are constantly renewed at the shores of the blood stream in the capillaries. Malignancy is ascribed to a cancer cell but it is not a recognizable characteristic of the individual cell. As can be demonstrated microscopically, the harm done lies in the volume of cells produced and in the uncontrolled and continuous formation of new capillaries far beyond the local demand and out of all systemic harmony, damaging and displacing the neighboring cells. They harm by insinuating themselves into, and crowding out the normal neighboring tissue. The appearance of what is generally called invasion of the normal tissue by carcinoma, is an invasion only in the mechanical sense. If we, with Bostroem, conceive the chronic irritation of the endothelial mesenchyme as due to a toxin circulating in the blood, it is but natural that this irritation will take place at numerous foci and that excessive cell formation will arise in many isolated parts of the affected tissue with normal tissue lying in between. The multiple small foci, situated near each other, will grow and finally coalesce into one mass forming the larger tumor. This multiple origin and growth of cancer has been observed and described by Virchow, who says: "A cancer does not grow from a centre outwards by simple cell division and addition but by the coalescence of many adjoining foci. Cancer as a tumor is not an outgrowth, an 'Auswuchs', but many foci grow one to another, forming an 'Anwuchs' and there is a progressive formation of new foci, a 'Nachwuchs'."

This manner of growth has been illustrated and proven by Margaret Warwick of Minneapolis, who by wax models of serial sections, has shown plainly that carcinoma does not start from one but from many papillae separated by normal epithelium. It would seem then that the real site of cancer disease is not in the single tumor nor in the so-called displaced embryonic cell of Cohnheim but in the pathologically stimulated capillary endothelial mesenchyme. The tumor we see is not the disease but merely a symptom. The disease is hidden and systemic, and, because of that, it stamps cancer not a primary and local but a general affection.

Surgeons with deep insight have always peered beyond the tumor cell for an explanation of the real cause of cancer. They have sensed the existence of a constitutional predisposition, a systemic vice, either hereditary or acquired. There is a something that so far has not been demonstrated, a disturbance that is present before the actual development of cancer tumor takes place. Freund aptly states: "Of the drama called cancer we know only the fifth act, the four others are as good as unknown." The deterioration of the blood, the general weakness, the signs of a general breakdown that often precedes the actual detection of the tumor, point to a primary systemic involvement. This involvement may be but temporary and need not necessarily lead up to tumor formation, but if it continues and when additional, perhaps exogenous causes, in the form of chronic irritation of any focus or foci supervene, then and only then, a tumor may develop and the final acts of the drama may unfold. Thus we distinguish between cancer, the systemic disease, and the local tumor colloquially called cancer. General carcinomatous cachexia to a varying degree precedes the actual development of the primary tumor and occasionally multiple tumors, known as metastases, are seen before a primary tumor can be found. The tumors in the regional lymph glands, generally known as metasases, are usually conceived as originating from

cancer cells ascending by way of the lymph channels to the respective glands. This thought, of course, is simply an application of what we know takes place in living bacterial infections. But cancer cells are not able to reproduce themselves and the explanation is, therefore, not applicable here. Furthermore, if these lymph-glands are examined microscopically and the cancer nodules examined as to their method of growth they are found to originate exactly like the primary growth did, i. e., from separate centres in the endothelial mesenchyme.

Owing to the laboratory success of causing formation of cancer in animals through external application of tar and also in consideration of the occurrence of so-called occupational carcinoma in man, the exogenous factors, as being the prime causes of cancer, have of late been very much in evidence and, I feel, over-rated. At least as far as the tar cancer in mice is concerned Lipschuetz has proven that the tumor formation is not a purely local process, but is the partial, though visible, evidence of a systemic tar intoxication developed after prolonged and repeated applications. Thus, a systemic vice even here is a requisite before actual tumor formation can take place.

It is conceivable that if for some reason the supply of the enterogenic toxin should cease, the disposition to unlimited cell growth would be lost, and the disease cancer would then cease spontaneously. Again, it is also conceivable when a cancerous tumor actually has developed, that, with the cessation of the supply of the enterogenous toxins, uncontrolled proliferation of the endothelial mesenchyme would also cease, the existing and short-lived cancer cells would die and a spontaneous cure result. Just what stops the further supply of toxins is "the mystery". That such spontaneous cures do take place, of that there can be no question, though the explanation is still lacking. But how can we explain the not negligible number of surgical cures of cancer by excision? With our conception that the diseased condition of the endothelial mesenchyme is the real seat of the trouble, the surgeon should despair of the permanency of his cure, and often enough this is the case, unless help comes from other sources.

To understand the permanent results after a radical excision of the breast and, more difficult yet, to explain the occasional cures after only partial excision of a tumor, where we know that a certain amount of cancerous tissue is left, we must bear in mind that often enough cures have resulted, apparently in consequence of various medication (like arsenic or intravenous or hypodermic injections of various sorts.) We must also bear in mind the far-reaching revulsive effects of an operation that may serve to augment the resistance of the endothelial mesenchyme to toxic stimulation, of changes in diet or of the beneficial effects of energetic after-treatment as well as of those cures that we consider as spontaneous. Perhaps refections on these possibilities may explain something.

The function of epithelial tissue is that of protection, respiration, digestion, metabolism and absorption. To perform all this work regeneration of its cells necessarily is very active and outstrips that of any other kind of cells. Where connective tissue growth, like bone, muscle, etc., is comparatively active as it is in the young, there is no cancer. When this connective tissue growth lags, as it does in persons after middle age, cancer may appear. In wild animals and in uncivilized man, connective tissue formation is ever at a high level and when it slows up the animal weakens and will succumb in its fight for existence. There is no cancer among savages or wild animals; it appears in man with civilization and in animals with domestication. The physical benefits civilization and domestication have conferred upon the races and individuals have been those of body comfort, protection and the ease of getting their food. To get this food now requires no great muscular effort, no great strain on the connective tissues. In consequence civilized man has less and poorer connective tissue but a very efficient epithelial tissue. Civilization and domestication often lead to over-eating and over-feeding and in consequence the activity of the glandular organs to digest, absorb, assimilate and metabolize is greatly strained and work hypertrophy of the glands results. Thus, civilization through the progress of thousands of years, has had opportunity to develop the overfed individual with diminished connective tissue

but excessive epithelial tissue, resulting in a predisposition to cancer. It is a clinically recognized fact that the well-fed, robust, plethoric individual, the type one would think most likely to withstand disease of any kind, is the one most suited to cancer. In my own practice I cannot recall a single individual suffering from carcinoma of the gastro-intestinal tract, of the breast, uterus, mouth, etc., who or whose immediate ancestors have not, previous to the development of the tumor, been of that type.

Wilhelm Gemund of Aachen has written a book about the "Wesen and Entstehung der Krebsdisposition" ("Nature and Origin of Cancer Disposition"), in which he describes and biologically deduces what I have briefly stated, and comes to the conclusion that as a result of civilization a constitutional tendency to excessive epithelial cell formation arises which manifests itself in a predisposition to cancer. The impression I have received from treating cancer patients, during 41 years of practice, has made it easy for me to accept these explanations and to make his reasoning my own.

SUMMARY

I, therefore, believe that cancer is a systemic disease and its predisposition a systemic vice.

The tumor is but its local manifestation.

Metastases are not spread from the primary tumor but are individual growths and are due to the same primary disease of the endothelial mesenchyme.

Cancer of the race cannot be fought successfully by treating the individual cancer but must be attempted by measures that have a prophylactic value. These are:

1. Increased muscular activity entailing better connective tissue development and (2) prevention of overfeeding and of the formation of an enterogenous toxin, thus avoiding excessive and uncontrolled epithelial cell proliferation.

We must point out the danger of cancer to the plethoric, non-active type of individual.

The diagnosis of the disease cancer in the pre-tumor stage is essential and is possible.

The disease should be suspected in all well-fed individuals who for reasons not otherwise detected, lose weight, become anaemic and complain of general abdominal disturbances. The treatment at this stage should be in charge of the internist and surgeon and consist in well planned efforts to build up the muscular system, removal of enterogenous toxins from the colon and in the avoidance of excessive nutrition. If a tumor has developed, even if large, it should be removed whenever possible so as to avoid its mechanical and mental effect as well as to prevent a breaking down of the tumor and additional cachexia and sepsis. All successive tumors that may form should be removed. Our means of removal are competent surgery and in some instances irradiation. When the tumor is removed the cancer must not be considered cured. The patient then requires special treatment for the cancer disease. This post-operative treatment is very essential and requires great skill and perseverance. For this there are many, but there is no one remedy, just as there is no one remedy for tuberculosis. Retirement from business followed by an easy, well-fed, inactive life, favors the development cancer.

Combined Roentgenologic and Clinical Differential Diagnosis of Benign and Malignant Lesions of the Stomach*

By B. R. KIRKLIN, M. D.
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and
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In Europe the roentgenologist commonly adheres to his rights as a clinical consultant and makes his interpretations in the full light of the clinical facts. In America the lines between these special fields are drawn more sharply; the roentgenologist bases his tenta-

* Synopsis of a paper presented before State Medical Society of Wisconsin, Madison, Sept. 11, 1931.

tive diagnosis almost solely on roentgenologic data, and the clinician derives his first opinion from the anamnesis and physical signs. This independent study enables both roentgenologist and clinician to conduct their investigation without prejudice; it stimulates them to cultivate their respective fields more intensively and thus promotes progress. Such study implies, however, that the clinical and roentgenologic data will be correlated in establishing the final diagnosis, and the necessity of thorough correlation in order to distinguish between benign and malignant disease of the stomach will be emphasized in this paper.

Carcinoma of the stomach may take the form of a frank tumor, an infiltrating neoplasm without evident tumefaction, an ulcer without manifest proliferation, or an ulcerating tumor in which both tumefaction and ulceration are obvious. Often in advanced cases of all four varieties the roentgenologic signs are fairly decisive. A medullary carcinoma manifested as a large defect which corresponds to a palpable mass, an extensive scirrhous carcinoma narrowing the lumen to an irregular funnel, a malignant ulcer with a diameter of 3 cm. or larger, or an ulcerating carcinoma with a crater surrounded by a prominent overhanging wall, is not likely to be mistaken for any of the benign lesions. Benign tumors are often multiple, usually pedunculated, and produce rounded central defects. Syphilis tends to narrow the gastric lumen symmetrically, and the gastric wall is rarely palpable. Benign ulcers with few exceptions are less than 3 cm. in diameter. Likewise, in advanced carcinoma of any variety the anamnesis and general examination are often reasonably diagnostic. If the patient has passed the early decades, if he gives a history of vomitus having the appearance of coffee grounds, if he has lost weight progressively, is obviously cachectic or anemic, with a palpable mass in the epigastrium, a clinical diagnosis of gastric carcinoma will usually be sustained. Nevertheless, even in cases of well-marked disease, the roentgenologist's criteria of distinction are not always reliable, and he may confound carcinoma with benign tumor, or fibromatosis with syphilis, and a large ulcer which is considered to be malignant may in fact be benign. Similarly, a definite clinical syndrome which is characteristic of carcinoma or of benign disease may be deceptive. Hence, however typical the case may seem, neither roentgenologist nor clinician can safely dispense with the correction or corroboration which the other may supply, and their coöperation should be not merely passive and perfunctory but active and thorough.

Such coöperation is even more necessary in determining whether a niche ulcer of moderate size, or a small prepyloric lesion, is malignant or benign. In the effort to make this distinction the roentgenologist is obliged to consider slighter morphologic changes and secondary phenomena, and the clinician must take note of minor symptoms and signs. Roentgenologically, a conical or irregular form of the niche, obliteration of rugae about the crater, absence of tenderness to pressure, gaping of the pylorus and absence of spastic manifestations suggest that an ulcer is malignant. An ulcer on the greater curvature is almost invariably malignant, and one on the posterior wall remote from either curvature or one near the pylorus is more likely to be malignant than an ulcer near the angle of the stomach. In contrast, an ulcer with a regularly hemispherical niche, situated near the angle, surrounded by converging rugae, and accompanied by marked spasm, localized tenderness, active peristalsis, spastic pylorus and curling of the antrum toward the median line, is probably benign. However. the signs which speak for or against malignancy of an ulcer vary in their combinations and emphasis, and the roentgenologist may misinterpret them or be left in doubt. It is especially difficult for him to identify small, prepyloric lesions. Early scirrhous carcinoma, syphilis, hypertrophy of the pyloric ring, and ulcer, whether simple or carcinomatous, often produce similar manifestations, and the roentgenologist is obliged to restrict his diagnosis to "lesion at the outlet." In all such cases combination of roentgenologic and clinical data may lead to a correct specific diagnosis.

On the clinical side the malignant nature of an ulcer may be evidenced by a change in the character of the symptoms, such as:

(1) change from an intermittent to a remittent or continuous course; (2) irregularity, diminution or disappearance of the "pain-food-ease" sequence; (3) substitution of the usual pain or distress by a more or less constant dull ache, and (4) onset of nausea and loss of appetite. Objectively significant signs may be progressive anemia in the absence of gross hemorrhage, loss of weight and strength out of proportion to reduction of food, a combination of advanced age and recent symptoms, early gastric retention with achlorhydria, persistent achlorhydria and blood in the gastric content, fasting residuum in the absence of retention of the six-hour barium meal, and the occurrence of many cases of carcinoma in several generations. In difficult cases the effect of hospitalization and adequate medical treatment may be decisive. It can be assumed that an ulcer which heals is benign. The converse is not necessarily true, but if the ulcer fails to heal, surgical interference is indicated.

Certain clinical features may give substantial aid in distinguishing benign from malignant tumors. Highly important is the fact that benign tumors are rare, their ratio to malignant tumors being 1:200; hence in doubtful cases the law of probability favors a diagnosis of carcinoma. However, benign tumors are generally characterized by absence or mildness of dyspeptic symptoms, normal acidity and volume of secretion, good state of nutrition, and low incidence of obstruction. The outstanding signs are anemia and gross gastro-enteric hemorrhage. The age of the patient may be significant, for many children have been found with benign tumors.

It is from a combination of roentgenologic and clinical data that distinction between benign and malignant disease often must be made, if it can be made at all. Each case constitutes an individual and novel problem, for the signs and symptoms vary endlessly in their associations, clarity and weight in the particular circumstances. To evaluate them properly a personal conference of the examiners is almost indispensable. At present, communication between the roentgenologist and clinician is too often restricted to a brief, form report in which neither examiner will venture beyond facts of which he is certain. From discussion and comparison of apparently trivial data and indefinite impressions may come an illuminating reëxamination, a more explicit opinion, or a specific and accurate diagnosis.

Eye Diseases From Nasal Causes

By ALBERT BARDES, M. D.
Milwaukee

There was a time when physicians, engaged in eye work, gave but scant attention to the nose as a causative factor in eye troubles. This is no longer so, and rightly, because every form of eye trouble has in many instances been traced to some nasal anomaly. This does not seem strange when we consider the intimate relationship between the orbit and the nasal sinuses. Three fourths of the circular orbital walls are also the walls of the nasal sinuses. In short, the sinuses almost surround the eye, and in certain places their walls are extremely thin and easily perforated. At once it becomes apparent that the sinuses must be reckoned with in dealing with serious, and particularly with obscure, lesions of the eye.

The ocular conjunctiva is closely connected with the nasal mucous membrane, and through the tear duct a nasal infection is readily transmitted to the eye. There are other ways in which a nasal disorder can affect the eye, as, by pressure of a distended sinus wall; by its suppurative erosion, and indirectly, by influencing the nerve supply, and the blood flow of the eye.

Even in early life, eye trouble from a nasal focus is in evidence, for the epiphora, from which some new-born infants suffer, is an indication of the occlusion of the nasal duct. Fortunately, this annoying condition is usually but temporary, for as development proceeds the constriction relaxes and the watery eye of the infant becomes normal. It is unwise to pass a probe into the tear-duct of a young baby because of the abrasions that are apt to be produced.

Later in life, the intimacy between the mu-

cous membrane of the eye and of the nose is again in evidence in the congested eye that accompanies acute fevers, and in severe attacks of rhinitis, of any form. Nearly all disorders of the lachrymal sac and of its ducts start in the nose. It is extremely easy for the lachrymal sac to become diseased from the ethmoid cells, with only the frail lachrymal bone intervening. Kuhnt, upon examining a large number of tear-duct cases, found a nasal disorder in nearly all of them.

Although the nasal sinuses are not fully developed until after adolesence, the undeveloped anterior ethmoid cells in children are often the seat of extensive disease. The infected discharge from diseased sinuses and from adenoids is a potent cause of conjunctivitis, and of corneal ulcer, so common in children. Broadening of the root of the nose in a child—the so-called frog nose—is usually indicative of either chronic ethmoiditis or of syphilis, either of which is apt to retard the functional development of the eye. Frequently, an ethmoid abscess breaks into the orbital cavity, producing orbital cellulitis or may be an orbital abscess. Should this occur, the eye is displaced downward and outward, with consequent impairment of vision and there is marked swelling and oedema of the eye-lids. Sometimes this is a grave condition and must be speedily rectified. Often these infective diseases of the eye, in children, fail to yield to treatment until the under-lying nasal disorder has been remedied.

Sinus diseases in general usually start in the anterior ethmoid cells from an attack of rhinitis. Extension to the other sinus is by continuity. The anterior ethmoid cells, because of their location, are better ventilated and are more effectively drained than the other sinuses are, therefore, if they become diseased they often get well automatically, while the less favored sinuses remain diseased. The latter are the principal sources of eye infection in adults.

The diagnosis of disease involving the frontal sinus, the anterior ethmoid cells, or the antrum, is attended with no difficulty. The localized pain, tenderness, and possibly swelling over the respective sinus, are the determining factors; but when the posterior ethmoid cells, and the sphenoid sinus are implicated, the diagnosis is more difficult. Disease of the sphenoid can exist for a long time and even run its course to a fatal termination without producing symptoms other than deeply seated pain, and often this is absent. Thus, in eye troubles of presumably unknown origin, the posterior ethmoid cells and the sphenoid sinus should be explored, even though the anterior ethmoid cells appear normal.

The sphenoid sinus is next to the optic nerve and close to the other nerves and vessels that pass through the three orbital openings at the back of the eye. This explains the occurrence of optic neuritis, scotoma, and other fundus affections of the eye, from sinus disease. Quite often definitely grave ocular symptoms yield, after a seemingly healthy sphenoid has been freely drained.

Glaucoma, and even cataract, are sometimes adversely influenced by sinusitis, probably through the retardation of the vascular flow. Contraction of the visual field, particularly for red and green, is a frequent outcome of sinus disease, also enlargement of the blind spot. Iridocyclitis occurs less often. The presence of choked disc of unknown origin should always lead to an investigation of the sinuses. This serious eye lesion, unless promptly relieved, merges into optic nerve atrophy and blindness.

It is well known that temporary impairment of the sight sometimes follows a nasal operation in the ethmoid region. Conversely, dimmed vision is often improved by an operation in the same region. Many cases of asthenopia and diplopia have been corrected by work upon the sinuses.

The antrum of Highmore is not often implicated in eye disorders. When it is, the ocular symptoms are pain in the floor of the orbit, swelling of the eye-lids, and conjunctival redness. A few words about the antrum: Because of its accessibility, it is all too often operated upon, and many healthy antrums become infected by being injudiciously irrigated, or too often irrigated. When this sinus is diseased, it is often because it has become infected from the other sinuses. Less often the infection comes from an abscessed tooth. Removal of the cause should be a preliminary consideration.

The outlet of the antrum of Highmore in the middle meatus is just below and close to those of the other sinuses. Therefore, it offers a most inviting entrance to the drainage from the other sinuses, so that fluid in the antrum frequently represents the overflow of the sinuses above.

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THE JOURNAL CLINIC

Contact Tests in Eczema

By MAURICE J. REUTER, M. D
Milwaukee

Until recent years, it was the consensus of opinion that eczema was a dermatosis, the result of endogenous disturbances. To date, complete failure has been the result of the numerous investigations that have been undertaken to obtain exact and scientific evidence of the existence of an internal disorder, either metabolic or infectious, which is present in all the many types of eczema and which is always associated with this disease of the skin. Fundamentally, then, eczema is apparently not an endogenous disease, the result of metabolic or infectious disorders. That metabolic changes and disturbances of the sympathetic and endocrine systems, heredity, and other factors may play a predisposing or contributory role is probably true, but this can be confirmed only by further investigation.

As Highman so aptly states, eczema and dermatitis have been regarded, in a rather uncritical and illogical way, as two distinct diseases. The separation of these two diseases has been based on a false hypothesis which holds that there exists in dermatitis, but not in eczema, a recognized, external irritant. This division is untenable because clinically and microscopically the two diseases are identical. Therefore, throughout this article the terms eczema and dermatitis will be used synonymously.

In the past few years, definite advances have been made in the appreciation of the etiology and in the treatment of eczema. Today, perhaps the majority of well informed dermatologists concede that eczema and dermatitis are identical and that the greater percentage of these cases are the result of sensitization of the skin to some external agent. In other words, eczema probably represents an allergic reaction and is the result of the contact of the skin with a substance to which it is sensitive. In theory, the skin, by previous contact has become sensitive by the formation of its own, specific, fixed, cellular antibodies, so that, on again coming in contact with the offending substance (antigen), the skin reacts with the formation of an inflammation. In other words, eczema or dermatitis results.

This conception has radically changed our clinical approach to eczema. No longer does our first thought lead to the performance of liver and kidney functional tests, blood chemical studies, basal metabolic rates and the institution of purely empirical dietary regimes, but, instead, our efforts are directed both toward the taking of a careful clinical history to determine, if possible, the causative external agent and toward the performance of "contact" tests.

In patients with acute or chronic eczema, where a comprehensive history does not readily reveal an obvious external agent as the real basis for the disease, "eczema", or "contact", or "patch" tests are done. These tests are not to be confused with the so-called "skin tests" with which we are all familiar, but which in the past have been of little or no value to the dermatologist from the standpoint of eczema. The occasional value of the intracutaneous skin tests, however, in other types of allergic dermatoses, such as urticaria and angioneurotic edema, besides other diseases not involving the skin, such as asthma and hay fever, cannot be denied.

In the performance of the contact tests, substances are used which might be etiologic agents in a given case and which seem especially indicated by the occupation or care-

fully compiled history of the patient. For example, in eczema about the face and neck, the test substances that come up for question might include hair dyes, scalp lotions, mouth washes, cosmetic preparations, furs, fur dyes and plants.

METHOD

The contact test is done by placing on the intact normal skin the test substance and then covering the substance with a piece of gauze, which is again covered with gutta percha or oiled silk and held in place with adhesive tape. If the test substance is a liquid, the gauze is soaked with the fluid before applying. It is possible to perform several tests at once using a separate area of the skin for each individual test substance. Only a small amount of the test substance is necessary and with the gauze and gutta percha in place, the entire area of skin covered need not be greater than two (2) to four (4) centimeters square. The tests are read after 24 hours and then at 24-hour intervals for three to ten days. In order to be considered positive, the test must show a reaction in the form of an eczema or dermatitis, that is, by the appearance of erythema, swelling, papules and vesicles.

EVALUATION

There are many factors to consider in the proper evaluation of contact tests: First, the contact test may reveal only one substance to which the patient's skin reacts, but, at the same time it may be sensitive to one or several other substances that have been overlooked and with which it has not been tested; then, despite the elimination of the positive substances the dermatitis may continue. A negative test does not always mean that the substance used in the test was not the cause of the eruption, as apparently the skin may spontaneously lose its sensitivity.

Again, the patient's skin in the area tested may not be sensitive to the substance in question, as theoretically the antibodies may be present and fixed in the epidermal cells only in the areas where the dermatitis occurs. Finally, we are justified in assuming a particular agent to be the etiologic factor in a given dermatitis only if the dermatitis subsides on

removal of the substance from contact with the skin.

As a result of the development and use of the contact test external elements have come more and more to the fore as the real causative factors in many cases of dermatitis or eczema. In many instances, where the condition has been considered as endogenous in origin, external irritants have been definitely proved to be the real etiologic agents, and the dermatitis has been cured by allowing the skin no contact with the substances to which it is sensitive. The list of agents, which, although innocuous to the average person, are capable of producing a dermatitis on contact with a given sensitive individual, is steadily growing. It might be added that up to the present time information obtained by the use of the contact test has been of greatest value in acute dermatitis.

While the allergic conception, that is, an antigen-antibody reaction, has not been definitely proved, there are many factors which are best explained by this theory. In fact, it has been through the application of the allergic conception in regard to dermatitis that the contact test, which has been of decided aid in the handling of these patients, has been developed. Only time and further investigation will prove whether eczema or dermatitis can be classed with other allergic diseases such as urticaria, angioneurotic edema, asthma, hay fever, and serum disease which have in many cases been proved, by the method of Praunitz and Kustner, to be the result of an antigen-antibody reaction. The common association of hay fever, asthma and eczema speaks further for the probable allergic nature of eczema.

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EDITORIALS

OPPORTUNITY FOR ALL

CERTAIN questions regarding research were aroused by a recent lecture given by Dr. Ivy of Northwestern University in which he reviewed some of his work relating to gastric physiology following resection of the stomach. The nature, results of his work, and its value are well known to all, and his perseverance and thorough investigation of this particular field over a period of fifteen years has aroused general admiration. His record might well serve as an example for others who would like to engage in research.

The urge to pursue research is a universal one. Perhaps no other longing is so frequently expressed by the man in practice, as this, that he might engage in research instead of the humdrum, everyday duties of clinical practice. Unfortunately a definite objective is usually not established by the average individual, and after preliminary skirmishing the vast majority with such ambitions allow them to die of inanition.

It would seem that the successful type of research temperament has a certain childlike inquisitiveness and curiosity mixed with optimistic perseverance as its fundamental characteristic. Unless this exists in an individual, his work is apt to lack force and vigor and quite often results in frustration and disappointment. To pick out the individuals who promise to have this vital force is difficult, and many tragic mistakes have been made by those in a position to determine the future of an aspirant in this field of work.

In most instances research work to be successful must be exhaustive and persevered in to a point where the problem is actually settled. Depending upon the problem this may be a matter of months, years or a life time. The majority of research workers never realize a successful completion of their particular problem. All they can hope is to gather additional facts from which the ultimate truth can be ascertained. Those who do achieve success are usually the recipients of great honors, but such honors are only for the few.

While other pastures always appear more inviting, the man in clinical practice has innumerable opportunities for investigative work which may be as promising as any carried out in research institutions. The careful observation of cases and recording of data from which comparisons can be made from time to time represents one of the most important forms of research. This opportunity is always present and waiting for any practitioner with the necessary ambition and requisite amount of energy to carefully study and keep accurate records of important cases. No less an authority than MacKenzie considered this the most important field for investigation, and he felt that the practitioner enjoyed the greatest opportunity for investigative work. A reasonable amount

of curiosity and imagination, sufficient energy to carry on concerted observations and an insatiable thirst for knowledge are the necessary ingredients from which a successful research worker can be made in or outside of a formal research institution. J. H.

SILICOSIS

IN THE words of Dr. Pancoast, of the University of Pennsylvania, Silicosis is rapidly becoming, if it is not already, one of the foremost medico-legal problems of today. It is also one of the major industrial hazards and the solution of the problem will require the close cooperation of the medical and legal professions, the industries concerned, and, last but not least, the workers themselves.

While the dangers of dust inhalation have long been suspected, it is only within the present century that the significant facts have been separated. It is now fairly well recognized that the dangerous element in dust is silica. This element reaches the pulmonary system by inhalation. The major portion of such material is caught in the upper respiratory tract or larger bronchi, by the mucosa and its secretions, and eliminated before damage occurs.

Following long or excessive exposure, however, this protective mechanism becomes inadequate and the dust reaches the distal portions of the pulmonary tree. Here it is taken up by phagocytes of the reticulo-endothelial system, of which a certain proportion migrate to the regional lymph nodes. Silica exerts a destructive influence on the phagocytes and leads to their dissolution. The free silica then produces irritation of the lymph structure in which it rests, with increased fibroblastic activity and resultant fibrosis. As the pathological changes increase this tissue destruction and fibrosis produces multiple obstruction of lymph channels, secondary diversion of drainage to other lymph systems, particularly towards the pleura, and finally marked pleural thickening.

As the fibrosis increases pulmonary ventilation is reduced and dyspnea becomes a permanent symptom. Local resistance to latent tuberculosis, or fresh exposure, is diminished, making the ravages of this disease deplorable among these unfortunate individuals. Once the disease becomes firmly established, the outlook remains dubious even with removal from further dust exposure because of the progressive toxic action of the silica on the tissues harboring it.

The medico-legal importance of this condition rests on the general association of dust with many industrial activities and the difficulty, at present, in assessing proper valuation to the many factors contributing to the disability in a given case. The lack of agreement regarding the diagnosis in the early, and possibly curable stage of the process, seems to be the major difficulty at present. The liability of the employer for sickness occurring as a result of silicosis, subsequent to employment and the heavy disability penalties associated with such illness may necessitate extensive inquiries regarding previous employment, and very possibly stereoscopic chest x-ray examination, before new applicants are accepted for employment.

Studies by the United States Public Health Service indicate that removal of dust at its point of origin is the most successful preventive measure. The use of masks and similar types of breathing apparatus have been found to be impractical. Carelessness on the part of the workers is one of the major elements in the problem. J. H.

SHARING KNOWLEDGE

"UNQUESTIONABLY one of the great advances made for the happiness of mankind is the determination of the medical profession, particularly of the United States, to share its knowledge with the people,—to talk medicine in language the people can understand."

This statement by the Editor of the Journal of the American Medical Association, Dr. Morris Fishbein, but emphasizes the importance of educational work undertaken by our own State Society through its press service sending an article a week to over 300 newspapers of the state, through its radio addresses, its presentation of Hygeia, to public officers and prominent laymen, and through encouragement of public addresses by its members. (Now turn to page 52.)

THE PRESIDENT'S PAGE

DISTRIBUTION OF MEDICAL SERVICE

PURSUANT to a resolution passed in the last House of Delegates, the President has appointed Dr. Gilbert Seaman, chairman, Dr. D. E. W. Wenstrand, and Dr. Gunnar Gundersen, a committee of three, to pursue the study of the distribution of medical service in Wisconsin. In its broadest aspects, the purpose of such an undertaking is an attempt to formulate a plan which in its operation shall solve what Dr. Olin West, Secretary of the American Medical Association, has designated as the greatest problem in American medicine, namely, to make available to all the people everywhere, all that is best in medical service at a price commensurate with the ability of the patient to pay.

In an attempt to collect and systematize the data from which the desired conclusions may be drawn, the committee will probably find itself essentially a fact finding body. It will require a study of the whole subject of the distribution and cost of medical service from several points of view—that of the physician, that of the layman, of such agencies as have been employed in this State to render to the people a service which they do not or can not pay for, and possibly a fourth in a study of what other States have attempted in this matter.

It is necessary that we recognize the fact that the practice of medicine is essentially a social function. Its purpose is to conserve the vital resources of the State. It is because it is a social function that the work which the physician performs is considered an adjunct to the State's obligations to its citizens, and only those whom the State considers qualified, are allowed to practice medicine, and must give proof through examination and licensure, of their ability and qualifications to satisfactorily perform this function.

What are some of the facts which this committee will ascertain? First, the distribution of physicians in the metropolitan, in the urban, and in rural areas. Where are the 2,800 physicians of the State located? Are there any people so situated that the services of the physician are not readily available to them? Are facilities in the way of hospitals, laboratories and libraries within easy reach of those in need of them? Are medical fees too high? Are they too low? What should be the income of a physician, taking into consideration his investment in time, money, and equipment, his hours of labor and the responsibilities which he assumes as compared with men in other professions or in business?

Is the public availing itself of such medical service as the profession is ready and anxious to afford? If not, is it because the service is not available, because of lack of appreciation of the service, or because of the cost of the service? What proportion of the population of the State of Wisconsin receives an income at or below the sum determined upon as the minimum required to maintain an American standard of living? What is the average cost of medical service to a family of five in this State? Can such cost be met out of an income below the minimum living wage? Is it possible to distribute the cost of medical service so as to lighten the burden and enable the public to avail itself of the service and at the same time assure the physician of a fair income?

The third topic of study is the gratuitous medical service afforded by official, semi-official, and lay organizations in Wisconsin. What kinds of service do they afford, to how large a number of people and what class of people? What is the total cost of such service? Is some of the work carried on by such organizations, service that should legitimately be in the hands of private practitioners? Are the State, municipalities, and counties, through various organizations and institutions, invading the field of private practice, and is such invasion a response to a demand on the part of the public for a service which the individual can not afford for himself? To what extent and along what lines is industry entering the field of medicine? Are public clinics, dispensaries, private clinics, groups, contract practice, a means employed to solve the problem of the distribution of cost of medical service, and if so to what degree do they accomplish their end?

Lastly, it would probably be helpful to study methods that have been instituted in an attempt to solve this problem in other industrial nations. How successful have such systems proven to be, both from the point of view of the public and the profession?

It will be seen that the subject is a very large one with diverse and many ramifications. The problem undoubtedly is too complex for the committee to secure all the data and make a complete survey in a single year. Even so, it is hoped that at the time of the next meeting of the State Medical Society, at least sufficient progress will have been made so that the committee's report will enable the members of the next House of Delegates to judge whether or not a further study is advisable or profitable.

The Budget Committee of the Council of the State Medical Society, realizing that this survey will require a great deal of time and much more work than the members of the committee can personally perform, has included in the suggested budget for the coming year the sum of $1800 to be used by the committee as it may deem advisable in the pursuit of its work.

It is to be hoped that every doctor in the State will co-operate with this committee to the fullest extent and that every physician will promptly and to the best of his ability, respond to every request made of him by the committee for data and statistics that will promote the study. It is only as we all do our several parts that we can hope to obtain reliable and sufficiently complete data to enable us to draw helpful conclusions.

THE STATE MEDICAL SOCIETY OF WISCONSIN

ORGANIZED 1841

OTHO FIEDLER, Sheboygan, President
REGINALD JACKSON, Madison, Pres.-Elect
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TERM EXPIRES 1934
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8th Dist., T. J. Redelings ...Marinette

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TERM EXPIRES 1933
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LIST OF EXECUTIVE OFFICERS OF COUNTY MEDICAL SOCIETIES

County	President	Secretary
Ashland-Bayfield-Iron	John M. Dodd, Jr., Ashland	J. W. Prentice, Ashland.
Barron-Washburn-Sawyer-Burnett	J. H. Wallis, Rice Lake	E. R. Hering, Shell Lake.
Brown-Kewaunee	E. S. Knox, Green Bay	W. E. Mueller, Green Bay.
Calumet	A. C. Engel, New Holstein	[illegible] Slaney, Hilbert.
Chippewa	F. T. McHugh, Chippewa Falls	J. A. Kelly, Chippewa Falls.
Clark	R. R. Rath, Granton	A. L. Schemmer, Colby.
Columbia	A. J. Batty, Portage	H. E. Gillette, Pardeeville.
Crawford	A. E. Dillman, Steuben	C. A. Armstrong, Prairie du Chien.
Dane	F. F. Bowman, Madison	F. L. Weston, Madison.
Dodge	E. P. Webb, Beaver Dam	A. W. Hammond, Beaver Dam.
Door	John Hirschboeck, Forestville	
Douglas	H. A. Sincock, Superior	C. H. Christiansen, Superior.
Eau Claire and Associated Counties	E. E. Tupper, Eau Claire	P. G. Spelbring, Eau Claire.
Fond du Lac	J. C. Yockey, Fond du Lac	H. R. Sharpe, Fond du Lac.
Grant	E. A. A. Dunn, Platteville	M. B. Glasier, Bloomington.
Green	W. B. Gnagi, Sr., Monroe	J. F. Mauermann, Monroe.
Green Lake-Waushara-Adams	J. M. Johnson, Ripon	A. J. Wiesender, Berlin.
Iowa	T. A. Hagerup, Dodgeville	H. M. Walker, Dodgeville.
Jefferson	A. C. Nickels, Watertown	A. A. Busse, Jefferson.
Juneau	C. A. Vogel, Elroy	A. T. Gregory, Mauston.
Kenosha	W. H. Bennett, Kenosha	W. H. Lipman, Kenosha.
La Crosse	R. L. Eagan, La Crosse	G. D. Reay, La Crosse.
Lafayette	R. B. Quinn, Darlington	W. B. Williams, Argyle.
Langlade	C. E. Zellmer, Antigo	J. C. Wright, Antigo.
Lincoln	F. L. Kelley, Merrill	W. H. Bayer, Merrill.
Manitowoc	W. G. Kemper, Manitowoc	C. H. Barnstein, Newton.
Marathon	Joseph F. Smith, Wausau	Verne E. Eastman, Wausau.
Marinette-Florence	T. J. Redelings, Marinette	C. H. Boren, Marinette.
Milwaukee	P. M. Currer, Milwaukee	Theo. Wiprud, Ex. Sec'y, Milw.
Monroe	A. E. Winter, Tomah	H. H. Williams, Sparta.
Oconto	R. J. Goggins, Oconto Falls	G. W. Krahn, Oconto Falls.
Oneida-Forest-Vilas	C. D. Packard, Rhinelander	I. E. Schiek, Rhinelander.
Outagamie	J. L. Benton, Appleton	R. V. Landis, Appleton.
Pierce-St. Croix	H. P. Conway, Spring Valley	A. E. McMahon, Glenwood City.
Polk	L. O. Simenstad, Osceola	Geo. B. Larson, Frederic
Portage	F. A. Marrs, Stevens Point	H. P. Benn, Stevens Point.
Price-Taylor	F. W. Mitchell, Medford	G. E. MacKinnon, Prentice.
Racine	J. F. Bennett, Burlington	Susan Jones, Racine.
Richland	Bertha Reynolds, Lone Rock	G. Benson, Richland Center.
Rock	H. E. Burger, Beloit	E. C. Hartman, Janesville.
Sauk	Roger Cahoon, Baraboo	A. C. Edwards, Baraboo.
Shawano	C. E. Stubenvoll, Shawano	L. W. Peterson, Shawano.
Sheboygan	H. F. Deicher, Plymouth	A. C. Radloff, Plymouth.
Trempealeau-Jackson-Buffalo	J. W. Lowe, Merrillan	R. L. MacCornack, Whitehall.
Vernon	W. M. Trowbridge, Viroqua	Wm. H. Remer, Chaseburg.
Walworth	S. G. Meany, East Troy	V. S. Downs, Lake Geneva.
Washington-Ozaukee	N. E. Hausmann, Kewaskum	P. M. Kauth, West Bend.
Waukesha	J. C. Hassall, Oconomowoc	J. F. Wilkinson, Oconomowoc.
Waupaca	R. K. Irvine, Manawa	F. J. Pfeifer, New London.
Winnebago	G. E. Forkin, Menasha	M. C. Haines, Oshkosh.
Wood	F. X. Pomainville, Wisconsin Rapids	W. G. Sexton, Marshfield.

SOCIETY PROCEEDINGS

BROWN-KEWAUNEE

The annual meeting of the Brown-Kewaunee County Medical Society was held December 12th at the Northland Hotel, Green Bay. Dinner was served at six o'clock. Immediately following dinner, a business meeting was held. This consisted of the reports of the Secretary and Treasurer and the election of officers. The following were elected:

President, Dr. E. S. Knox, Green Bay; Vice-President, Dr. D. B. Dana, Kewaunee; Secretary-Treasurer, Dr. W. E. Mueller, Green Bay; Delegate, Dr. R. M. Carter, Green Bay; Alternate, Dr. W. M. Wochos, Kewaunee.

Dr. W. E. Leaper, Green Bay, reported a case of double tubal pregnancy. As these cases are very unusual his report was very much appreciated by the Society. Following this, two very interesting and instructive films were shown through the courtesy of Davis & Geck, manufacturers of surgical catgut. The titles of the films were "The Relations of Absorbal Sutures of Wound Healing," and "Traumatic Surgery of the Extremities." Meeting adjourned. E. S. K.

CLARK

A meeting of the Clark County Medical Society was held on November 20th at the Merchant's Hotel, Neillsville.

Speakers of the evening were as follows:

Mr. J. G. Crownhart, secretary of the State Medical Society, discussed the aims and purposes of the Secretary's office.

Dr. J. B. Wear, assistant professor of urology, University of Wisconsin, gave an illustrated lecture on "What the General Practitioner Frequently Meets in the Field of Urology."

Dr. R. R. Rath, Granton, President of the Society, presided. A. L. S.

DANE

The Dane County Medical Society held a dinner meeting in the Hotel Loraine, Madison, December 8th.

Officers for 1932 were elected as follows: President, Dr. F. F. Bowman, Madison; Dr. Harry A. Keenan, Stoughton, Vice-President; Dr. Frank Weston, Madison, Secretary; Drs. L. V. Littig, Madison, and L. W. Peterson, Sun Prairie, Delegates; Drs. Albert Tormey and Louis Fauerbach, both of Madison, Alternates.

At this meeting the Society adopted an amendment to its constitution placing broad powers of administration in the hands of a board of trustees, eliminating the board of censors. The new board of trustees consists of twelve members, including the President, Vice-President, and Secretary of the Society, four members not residents of Madison, one member resident of Madison not on the staff of any hospital, and four others each representing the four hospitals in Madison. Following are the members of the board of trustees:

Dr. W. D. Stovall, representing Wisconsin General Hospital; Dr. James Dean, representing St. Mary's; Dr. L. V. Littig, representing Madison General; Dr. J. Newton Sisk, representing Methodist hospital. Dr. Karl W. Smith, Madison, represents physicians not on the staff of any hospital.

The four members chosen who are not residents of Madison are: Dr. L. W. Peterson, Sun Prairie; Dr. Karl K. Amundson, Cambridge; Dr. H. A. Sharpe, Verona, and Dr. B. W. Shaw, Waunakee.

DOUGLAS

Dr. H. A. Sincock, Superior, was elected president of the Douglas County Medical Society at its annual meeting held at the Androy Hotel, December 2nd. Dr. G. J. Hathaway, Superior, was chosen vice-president; Dr. C. H. Christiansen, Superior, was re-elected secretary and treasurer, and Dr. L. W. Beebe, Superior, was re-elected a member of the board of censors. Dr. T. J. O'Leary, Superior, was chosen as delegate to the annual meeting of the State Medical Society while Dr. C. W. Giesen was elected alternate delegate.

FOND DU LAC

Mr. Clayton Bond, business manager of the Sheboygan Clinic, was the principal speaker at a meeting of the Fond du Lac County Medical Society held in Campbellsport on December 9th. Mr. Bond spoke on "Economic Aspects of the Practice of Medicine."

GREEN LAKE-WAUSHARA-ADAMS

A meeting of the Green Lake-Waushara-Adams County Medical Society was held in Berlin at the Hotel Whiting on November 24th, which was preceded by a dinner.

Dr. J. M. Johnson, Ripon, was speaker of the evening, his subject being "Cancer" and a general discussion followed.

JEFFERSON

A regular meeting of the Jefferson County Medical Society was held November 19th at Forest Lawn Sanitarium, Jefferson. Talks, illustrated by x-ray films were given by Dr. R. E. Burns, Madison, on the treatment of fractures and Dr. A. A. Pleyte, Milwaukee, on pneumoconiosis.

The annual meeting of the Society was held Tuesday evening, December 15th, at the Jefferson House, Jefferson. The following officers were elected for the year 1932:

President, Dr. A. C. Nickels, Watertown; Vice-President, Dr. M. G. Peterson, Lake Mills; Secretary-Treasurer, Dr. A. A. Busse, Jefferson; Censor, Dr. W. C. Becker, Watertown.

Dr. V. W. Carlson, Lake Mills, was elected to membership in the Society. M. G. P.

LA CROSSE

The La Crosse County Medical Society held its regular meeting on December 15th, 1931, at 8:00 p. m. at the Pioneer hall.

The minutes of the previous meeting were read and approved.

A letter from the Secretary of the La Crosse Club was read. He informed the society that the room being used for the monthly meetings would not be available in the future for society meetings. The Secretary was instructed to investigate other accommodations suitable for monthly meetings. Places mentioned were: The Cargill Home, Y. M. C. A., and the Armory.

Dr. Eagan reported for the committee appointed to meet with the county board to discuss "Care of the Indigent Sick by Contract with the County Society".

The matter was discussed by members present.

A motion was made by Dr. James Evans and seconded by Dr. Alf Gundersen, that our delegate to the State Society bring up at the next meeting of the house of delegates the following proposition with the view of having it put before the state legislature for action: That as many county cases as possible be treated at the local hospitals, be paid the same amount in the same manner as the Wisconsin General Hospital, namely, $2.50 from the County and $2.50 from the State. The motion was carried.

Dr. F. A. Douglas made a motion seconded by Dr. P. C. Gatterdam that the subject of county hospitalization and care of the indigent sick be made the special order of business for the next meeting. Motion carried.

Mr. Murphy of the La Crosse Health Department gave a talk on "Our Local Milk Supply". It was discussed freely by the members. A motion was made by Dr. Alf Gundersen and seconded by Dr. Douglas that the society go on record as favoring the city of La Crosse except that used for commercial purposes. Also that a committee be appointed to notify the health department of the action taken by this society. The committee is authorized to give favorable publicity regarding milk pasteurization. Committee appointed: Dr. Alf Gundersen, Dr. N. P. Anderson and Dr. W. E. Bannen.

Election of officers by formal ballot for the offices of President, Secretary, and Treasurer and Censor for the year 1932 resulted as follows: President, Dr. R. L. Eagan; Vice-President, Dr. P. C. Gatterdam; Secretary-Treasurer, Dr. G. D. Reay; Censor, Dr. F. A. Douglas.

Meeting adjourned. R. L. E.

LANGLADE

The Langlade County Medical Society held its annual meeting at the Butterfield Hotel at 6 o'clock, December 17th. A fine dinner was served which was enjoyed by everyone present.

The meeting was called to order by the president, Dr. E. J. Donohue, Antigo. Minutes of the last meeting were read and approved as read. Communications read and discussed. Bills and other business were disposed of and resolutions passed. Fee bill continued the same as before, no raise in the charges in the medical and surgical treatment at this time. Election of officers for the coming year resulted as follows:

President, Dr. C. E. Zellmer, Antigo;

Vice-President, Dr. J. W. Lambert, Antigo;

Secretary and Treasurer, Dr. J. C. Wright, Antigo.

Dr. Wright was chosen as delegate to the state medical meeting which will be held in Milwaukee in September, 1932. Dr. Lambert was elected alternate.

At this meeting a resolution was passed regarding the illegal use and recognition of the title "Doctor." The resolution also specified that copies of the same be sent to those persons concerned. A copy was also to be sent to the Antigo Journal, which from time to time has referred to some of the individuals mentioned and has written notices or articles about them in which the title "Doctor" or "Dr." has been used. Attention is hereby called to the Wisconsin Statutes. The following is the resolution:

"Whereas, it has been brought to the attention of the members of the Langlade County Medical Society that various individuals in this community are gracing their trades, professions, or cults by the title 'Doctor' or 'Dr'., 'Specialist', etc., and in some cases have had their correspondence material printed with the above titles, and have had or have agreed to advertisements, and so-called professional cards incorporating these titles printed in the local newspapers.

"Be it resolved: That the attention of the individual referred to and the editors of the Antigo Daily Journal be called to the section of the Wisconsin Statutes No. 147.14 (3), 'No person not possessing a license to practice Medicine and Surgery, Osteopathy or Osteopathy and Surgery under section 147.17 shall use or assume the title 'Doctor' or append to his name the words or letters 'Doctor', 'Dr.', 'Specialist', 'Mr.', 'D. O.' or any other title, letters or designation which represents or may tend to represent him as a Doctor in any branch of treating the sick.'

"Be it further resolved: That copies of this resolution be mailed to the persons concerned and their attention drawn to the fact that the above willful misuse of the title 'Doctor' in violation of the statute subjects the individual to investigation and, if necessary, prosecution by the State Board of Examiners.

"Be it further resolved: That the local newspapers be advised by the Medical Society that whenever professional cards are ordered such cards

should be placed in a suitable space which is not to be used by above referred-to trades, professions or cults.

"Signed: Langlade County Medical Society
"By J. C. Wright, M. D.
Secretary."

After the business meeting, the smoker and an hour of social pleasure was enjoyed. J. C. W.

MARATHON

Dr. Frank E. Simpson of Chicago spoke on "Some Problems Connected With the Radium Treatment of Carcinoma" illustrated with lantern slides and motion pictures, at the meeting of the Marathon County Medical Society on December 15th at St. Mary's Hospital, Wausau.

MARINETTE-FLORENCE

The regular meeting of the Marinette-Florence County Medical Society was held at Hotel Menominee, December 10th, at six-thirty, with the Menominee County Society. Discussion of local problems followed the dinner and the movie films were shown entitled "Traumatic Surgery of Extremities" (Davis & Geck). The following local members were present: Drs. T. J. Redelings, M. D. Bird, H. F. Schroeder, A. T. Nadeau, G. R. Duer, H. W. Haasl, J. W. Boren and C. H. Boren. Meeting adjourned. C. H. B.

MILWAUKEE

A most enthusiastic meeting of the Medical Society of Milwaukee County was held on Thursday evening, December 10th. It was the annual dinner meeting of the Society, and was given in the Crystal dining room of the Hotel Pfister. The following officers, who had been nominated by the nominating committee at its meeting on November 12th, were unanimously elected:

President-elect, Dr. James C. Sargent; Secretary, Dr. Charles Fidler; Treasurer, Dr. John O. Dieterle; Director, Dr. E. L. Tharinger; Censors, Drs. Dexter Witte, and W. F. Grotjan.

Delegates to the State Society, 1932-33: Drs. A. A. Pleyte, S. G. Higgins, M. G. Peterman, Bernard Krueger, F. A. Thompson, D. E. W. Wendstrand, Edith McCann.

Alternates to the State Society, 1932-33: Drs. Millard Tufts, N. E. NcBeath, Lucius Hipke, William Jermain, S. H. Lippitt, R. A. Toepfer, U. A. Schlueter.

The principal speaker of the evening was Dr. Irving S. Cutter, Dean of Northwestern University Medical College. His subject was "The Future of Medical Practice".

Brief talks were made by Dr. Paul M. Currer, newly-elected President; Dr. James C. Sargent, newly-elected President-elect; Dr. E. L. Tharinger, retiring President, and Dr. Otho Fiedler, President of the State Medical Society.

There were 200 present.

OUTAGAMIE

The November meeting of the Outagamie County Medical Society was held November 17th at the Hotel Northern, Appleton.

Two films,—"Anatomy of the Female Pelvis and Perineum" and "Vaginal Hysterectomy for Uterine Prolapse" were shown by Mr. H. S. Howard of the Petrolagar Laboratories of Chicago.

POLK

On November 20 the members of the Polk County Society were the dinner guests of Dr. A. N. Nelson, Clear Lake.

Mr. Augustine, of Petrolagar Laboratories, ran two interesting films of moving pictures on medical topics.

Dr. Diamond, Frederic, discussed recent cases of abdominal and tubal pregnancies.

A report of the reaction of the poor relief authorities to the Society's 1932 proposal for the care of the indigent sick was given by the President. The poor relief authorities refused the figure offered by the Society and offered a figure of their own which was far below the figure agreed upon by the members. A motion carried to stand by our original figure, and if refused to go back on an individual basis.

A round table discussion followed covering the subjects of Child Health Centers and Maternity Aid Centers and the Wisconsin Anti-Tuberculosis Ass'n. The Secretary was instructed to arrange a meeting with a representative of each of these groups in an effort to become better acquainted with their programs.

The Polk County Society sponsored a joint meeting of the physicians and dentists of Polk County to discuss a combined public health program. The members of both groups were the dinner guests of Dr. Caldwell, St. Croix, on December 18.

The program: Mr. Robert Scott, Frederic, "Mental Diagnosis", L. O. Simenstad, M. D., "Organization", C. A. Nelson, D. D. S., "Panel Dentistry", R. G. Arveson, M. D., "Professional Relationships" and Mr. Geo. B. Larson, "Public Health Problems of Polk County." A general discussion followed covering the part of the two professions in the local public health program.

The members of the Polk County Society were invited to be the guests of the dentists at the joint meeting with Dr. Harper and Mr. Crownhart, to be held in Amery on January 22. G. L.

RACINE

The Racine County Medical Society held a meeting at the Racine Elks Club on Thursday evening, November 19th.

"Spinal Injury—Demonstrated by Moving Pictures" was the subject of an address by Dr. John W. Powers, professor of orthopedic surgery at Marquette University, and Dr. Carl H. Davis, professor of obstetrics at Marquette, spoke on "Plastic Pelvic Surgery."

SHEBOYGAN

The Sheboygan County Medical Society was invited by the Kohler Company to hold its meeting at the American Club at Kohler on November 24th.

After a six-thirty o'clock dinner and regular meeting, talking moving pictures of operations by Dr. H. O. Jones of Northwestern University were shown through the courtesy of Petrolagar Laboratories. These pictures are well worth while and were appreciated by the fifty members present from this and surrounding counties.

Former Governor Walter J. Kohler gave a short talk on the introduction of the first bathtub and the opposition it met by some of the medical profession because frequent bathing would be harmful, contrasting that belief with the present therapeutic use of baths in sanatoria.

The annual meeting of the Society was held at the Rocky Knoll Sanatorium on December 15th.

After a six o'clock dinner, the forty members and guests present listened to Dr. Louis M. Warfield of Milwaukee, who talked on "The Causes and Management of Heart Failure", and Dr. Oscar Lotz of Milwaukee, who gave a talk and demonstration on "Examination of the Chest."

Following the business meeting during which Dr. Wm. G. Meier of Sheboygan was elected to membership, the following officers were elected: President, Dr. H. F. Deicher; Vice-President, Dr. M. D. Cottingham; Secretary, Dr. A. C. Radloff; Delegate, Dr. R. C. Meyer; Alternate, Dr. C. J. Weber; Censor, Dr. Edmund Knauf. A. C. R.

VERNON

Members of Vernon County Medical Society met on December 9th at two o'clock in the Farmers Bank, Viroqua. The following officers for 1932 were elected:

President, Dr. W. M. Trowbridge, Viroqua; Vice-President, Dr. C. E. Lauder, Viroqua; Secretary-Treasurer, Dr. W. H. Remer, Chaseburg; Delegate, Dr. W. H. Remer; Alternate, Dr. John Schee, Westby.

The board of censors consisting of Drs. Schee, Surenson, and Charles Trowbridge, approved the applications of Drs. Hugh A. Rasmussen, Westby; Alvin E. Kuehn and R. S. Hirsch, Viroqua, to become members of the Society, and they were accordingly adopted as members.

Motion was made by Dr. Lauder, seconded by Dr. Ludden, that we promulgate a campaign in conjunction with the county and school nurses, to vaccinate all children, the doctors to do the work for fifty cents each. Carried.

Dr. Lauder was appointed a committee of one to interview the nurses regarding the above motion.

The financial report was read and approved on motion. Motion was made, seconded and carried to pay for flowers for funeral of Dr. C. V. Porter.

Motion was made by Dr. Ludden, seconded by Dr. Lauder, that a committee be appointed to investigate the indigent situation relative to adopting the Iowa plan, a resume of which was printed in the June issue of the Wisconsin Medical Journal. Carried. The following committee was named: Chairman, Dr. Hansberry; Drs. Surenson, Lauder, Charles Trowbridge, and W. M. Trowbridge. Following this, the meeting adjourned. W. H. R.

WALWORTH

Dr. S. G. Meany of East Troy was elected president of the Walworth County Medical Society at a meeting held in the Loraine Hotel at Elkhorn on December 8th. Dr. R. A. Mullen, East Troy, was elected vice-president; Dr. V. S. Downs, Lake Geneva, secretary and treasurer; Dr. R. C. Halsey, Lake Geneva, delegate, and Dr. T. L. Jacobson, Delavan, alternate.

WAUKESHA

The Waukesha County Medical Society met at Waukesha Springs Sanitarium and elected the following officers for 1932:

President, Dr. J. C. Hassall, Oconomowoc; Vice-President, Dr. R. D. Thompson, Statesan; Secretary-Treasurer, Dr. J. F. Wilkinson, Oconomowoc; Delegate, Dr. H. T. Barnes, Delafield; Alternate, Dr. H. A. Peters, Oconomowoc; Censors, Dr. W. S. Wing, Oconomowoc, Dr. A. J. Williams, Waukesha, Dr. J. B. Noble, Waukesha.

At this meeting Dr. Gilbert E. Seaman, Milwaukee, gave a very interesting talk on "Medical Economics and Social Medicine." J. F. W.

WAUPACA

The Waupaca County Medical Society held a regular meeting at the New London Community Hospital, following a six-thirty o'clock dinner on Wednesday, December 2nd.

Dr. Victor F. Marshall of Appleton talked on "Problems of Fractures" and Dr. F. Gregory Connell, Oshkosh, spoke on "Diseases of the Biliary Tract."

WINNEBAGO

The December meeting of the Winnebago County Medical Society was held with a dinner at the Raulf Hotel, Oshkosh, Wisconsin, December 18th, 1931, at 6:30.

At the business meeting Drs. P. Bell, J. J. Kronzer, and F. J. Brennan were admitted into the society and Dr. R. C. Lowe, formerly of Richland Center and now at Neenah, was transferred into the Winnebago County Society. The following officers for the year 1932 were elected: President, Dr. G. E. Forkin, Menasha; Vice President, Dr. D. G. Hugo, Oshkosh; Secretary, Dr. M. C. Haines, Oshkosh; Delegate, Dr. J. W. Lockhart, Oshkosh; Alternate Delegate, Dr. R. B. Rogers, Neenah; Censor, Dr. A. G. Koehler, Oshkosh.

Dr. A. C. Ivy, Professor of Physiology of Northwestern University Medical School, spoke on "Cholelithiasis"—an experimental study relating to etiology, symptoms and treatments. About 65 members

attended the meeting, Winnebago, Fond du Lac, Green Lake, and Waupaca Counties being present. M. C. H.

INTERURBAN ACADEMY OF MEDICINE

Dr. V. E. Ekblad, Superior, was elected president of the Interurban Academy of Medicine at an annual dinner meeting held November 18th at the Androy Hotel, Superior. Dr. H. A. Sincock, also of Superior, was chosen secretary-treasurer. Dr. Mario Fischer and Dr. P. S. Rudie, both of Duluth, were elected vice-president and censor, respectively.

MILWAUKEE ACADEMY OF MEDICINE

A meeting of the Milwaukee Academy of Medicine was held on Tuesday, November 24th. Talks on "Fever Therapy of Neurosyphilis" and the "Recent League of Nations Conferences of the Serology of Syphilis" were given by Drs. M. J. Reuter, Milwaukee, and R. L. Kahn, Ann Arbor, respectively.

The Academy met again on Tuesday, December 15th. Following the business meeting, a scientific program was presented, as follows:

"Newer Physiology of the Sex Cycle and its Practical Aspects in Gynecology" by Dr. R. M. Kurten, Racine.

"Hyperparathyroidism and Hyperinsulinism" by Dr. Nathan A. Womack, Washington University, St. Louis.

MILWAUKEE HOSPITAL INTERNS' ASSOCIATION

The Milwaukee Hospital Interns' Association will hold its first meeting of 1932 in the new section of the Milwaukee Hospital at 8 p. m., Wednesday, January 20th.

Reverend Herman L. F. Fritschel and Dr. C. A. Evans will appear on the program.

MILWAUKEE OTO-OPHTHALMIC

The Milwaukee Oto-Ophthalmic Society held its monthly meeting at the Wisconsin Club on Tuesday, December 15th. Dinner was served at 6:30 P. M., and was followed by an address on "Etiology Of Ocular Diseases," given by Harry Gradle, M. D., of Chicago.

MILWAUKEE PEDIATRIC

The last meeting of the year of the Milwaukee Pediatric Society was a dinner meeting held at the Convalescent Home of the Milwaukee Children's Hospital on Wednesday, December ninth.

The annual election of officers took place. The following were elected: President, Dr. G. H. Fellman; Vice-President, Dr. J. F. Shimpa; Secretary and Treasurer, Dr. George F. Kelly.

The scientific program consisted of papers as follows:

"Cerebral Hemorrhage of the Newborn" by Dr. Abraham Levinson of Chicago.

"Indications for Collapse Therapy in Children" by Dr. Karl Kassowitz.

Dr. J. Martin Sansby was elected to membership in the society. F. R. J.

NINTH COUNCILOR

The winter meeting of the Ninth Councilor District Medical Society was held Thursday afternoon, December 10th, in the lecture room of St. Joseph's Hospital, Marshfield. The following program was presented:

"Fibroid of Uterus Treated by X-Ray" by Dr. H. A. Vedder, Marshfield.

"Case of Renal Calculus and Cholelithiasis" by Dr. W. G. Sexton, Marshfield.

"Purpura Hemorrhagica" by Dr. K. H. Doege, Marshfield.

"Osteogenesis Imperfecta" by Dr. R. H. Juers, Marshfield.

"Adenocystoma" by Dr. Paul F. Doege, Marshfield.

"Ovarian Cyst" by Dr. J. B. Vedder, Marshfield.

"Cerebellar Tumor, Localization and Operative Findings" by Dr. L. A. Copps, Marshfield.

"X-Ray Demonstration of Hydrocephalus and Spinabifida In Utero" by Dr. R. P. Potter, Marshfield.

"Urinary Antisepsis" by Dr. W. F. Braasch, professor of urology of the Graduate School, University of Minnesota.

"Early Diagnosis of Cancer of Uterus" by Dr. Henry Schmitz, professor of gynecology, Loyola University Medical School, Chicago.

UNIVERSITY OF WISCONSIN

Dr. Henry E. Sigerist, professor of the history of medicine at the University of Zurich, gave an illustrated lecture on "Medicine of the Renaissance" before a meeting of the University of Wisconsin Medical Society held on December 10th in the Service Memorial Institutes building.

WISCONSIN UROLOGICAL

The regular fall meeting of the Wisconsin Urological Society was held in Milwaukee, December 4th and 5th.

The morning program on December 4th consisted of a symposium on "Urinary Tract Injuries", the following papers being presented:

"An Unusual Case of Ruptured Kidney" by Dr. Robert Irwin, Milwaukee.

"Bladder Perforation from an Ovarian Dermoid" and "Traumatic Rupture of a Hydronephrotic Kidney" by Dr. George H. Ewell, Madison.

"Gunshot Wound of the Kidney" by Dr. W. G. Sexton, Marshfield.

"Surgical Injuries of the Ureter" by Dr. Ira R. Sisk, Madison.

The afternoon program included the following:

"Renal Tuberculosis in Children" by Dr. Walter M. Kearns and Dr. S. M. Turkeltaub, both of Milwaukee.

"Additions to the Treatment of Syphilis During the Last Decade" by Dr. Maurice J. Reuter, Milwaukee.

"Debatable Questions in the Management of Gonorrhea in the Male" by Dr. Russell D. Herrold, Chicago.

"Chronic Seminal Vesiculitis" by Dr. Harry C. Rolnick, Chicago.

"Chronic Urethritis in the Female" by Dr. A. H. Gundersen, La Crosse.

On Saturday morning, December 5th, a two-hour discussion together with gross and microscopic demonstrations on "Pathology of Bladder Tumors" was conducted by Dr. E. L. Miloslavich, Milwaukee.

A paper by Dr. H. L. Kretschmer, Chicago, on "Treatment of Bladder Tumors" concluded the program.

THE WOMAN'S AUXILIARY

Mrs. Orvil O'Neal, Ripon, Editor

A letter has gone out from this office to all the county presidents requesting reports on activities of their organization.

Do you find yours here? Perhaps it was too late. Try to get all items to me by the first as I must have them in the Journal office by the fifth.

* * *

The Green Lake-Waushara-Adams County Medical Society met in Berlin, Nov. 19th. The Auxiliary members and the Doctors had an excellent dinner at the Hotel Whiting. The Doctors had their meeting at the City Library and the Auxiliary members went to the home of Dr. and Mrs. Casper.

A business meeting was held and the minutes and reports of the Ninth Annual Meeting of the Woman's Auxiliary to the American Medical Association, held at Philadelphia, June 8–12, 1931, were reviewed and discussed.

The year's work on the course of study recommended by the National Auxiliary was begun.

Following the meeting a social hour with the Doctors was enjoyed.

* * *

A Woman's Auxiliary is being organized in Milwaukee County under the able leadership of our State President, Mrs. Henry Gramling, 2203 S. Layton Boulevard. Mrs. Gramling has appointed state chairmen, and our organization work is well planned due to the interest of the chairmen.

Wherever medical societies give active encouragement to the formation of Auxiliaries, organization will go forward rapidly.

* * *

The mid-year meeting of the Board of Directors of the Woman's Auxiliary to the A. M. A. was held in Chicago, Friday, November 13th, at the Pearson Hotel. Twenty-three members were in attendance.

The report indicates that all chairmen are actively engaged in promoting their work, and that increased interest in every department of the Auxiliary is being shown by many of the State and County units.

Tentative plans were outlined for the program of the Annual convention which is to be held in New Orleans May 9-13th. It was decided to allow a two-hour period for conferences for those departments desiring a conference. The president announces that three conferences have already been requested,—one on organization, one on convention methods, and one on press and publicity.

It was felt by the members present that not enough states were being represented at the mid-year Board meetings, and that State Auxiliaries should be urged to make an allowance for their presidents' expenses for attending Board meetings and the annual convention.

* * *

The Woman's Auxiliary to The Medical Society of Milwaukee County, held its first meeting on Friday, December 11th, at the Hotel Knickerbocker. There were 156 present. The following were elected officers in the newly-created organization: Mrs. James C. Sargent, President; Mrs. Joseph Lettenberger, Vice-President; Mrs. Eben J. Carey, Secretary, and Mrs. J. F. Zivnuska, Treasurer.

The speakers at the meeting were Dr. Jessie Allen, of Beloit, Miss Ruth Buellsbach, assistant secretary of the State Medical Society, Dr. E. L. Tharinger, president of The Medical Society of Milwaukee County, and Mr. Theodore Wiprud, executive secretary of The Medical Society of Milwaukee County.

The next meeting of the Auxiliary will be held the second Friday of January, at which time a nominating committee will be elected.

* * *

The Woman's Auxiliary to the Columbia County Medical Society met at the Portage Hotel on December tenth and elected the following officers: President, Mrs. J. R. Kellogg; Vice President, Mrs. K. A. Snyder; Secretary, Mrs. H. E. Gillette; Treasurer, Mrs. J. W. MacGregor.

* * *

The Marinette-Florence County Auxiliary met on Dec. 5th at the home of Dr. and Mrs. T. J. Redelings. Five members were present, and the following officers were elected:

Pres. Mrs. J. V. May, 1421 Grant Street, Marinette.

Vice-Pres. Mrs. Francis DeSalvo, Niagara.

Sec. Mrs. T. A. Lid, 1602 Main St., Marinette.

Treas. Mrs. M. D. Bird, 1520 Main St., Marinette.

NEWS ITEMS AND PERSONALS

Dr. Francis Nimz, formerly of Iron Ridge, Wisconsin, is now resident physician at Grandview Hospital, La Crosse.

Dr. F. E. Butler of Menomonie suffered injuries and bruises when his car collided with a road grader near the Dunn County Asylum.

INCOME TAX DEDUCTIONS

Because income tax law revisions are now pending in the Wisconsin Legislature and Congress, the usual publication of data pertaining to deductions permitted the profession will be withheld until the February issue.

Dr. E. A. Pohle, of the department of radiology, University of Wisconsin, attended the 17th annual meeting of the Radiological Society of North America at St. Louis, Mo., November 30 to December 4, 1931. Besides leading a symposium on "Grenz Ray Therapy", he also presented a paper on "The Behavior of Air-Cooled X-Ray Tubes Operated on Transformers with Valve Tube Rectification and Condensers."

—△—

Dr. C. B. Richards of Waldo has been elected trustee of Rocky Knoll Sanatorium, Sheboygan, to replace Dr. W. F. Zierath, recently resigned. Dr. Richards has been practicing in Waldo for the past two years and is a member of the Sheboygan County Medical Society.

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Speaking on "The Nervous Child," Dr. Francis Paul, Madison, addressed the Parent-Teacher Association of Evansville at its regular meeting in December.

—△—

Dr. W. A. Deerhake, superintendent of Central State Hospital for the Insane, Waupun, was speaker before the Woman's Club of Beaver Dam on November 30th.

—△—

Archbishop Samuel A. Stritch of Milwaukee was principal speaker at the dedication ceremony of the new St. Agnes' Hospital School of Nursing at Fond du Lac.

—△—

Dr. Hugh P. Greeley, Madison, has removed his offices from 1 South Pinckney Street to 905 University Avenue.

—△—

Dr. W. W. Bauer, Racine health commissioner for eight years, and formerly connected with the Milwaukee Health Department, resigned, effective January first, to assume his new duties with the American Medical Association.

While health commissioner of Racine, Dr. Bauer planned the work which won the distinction for the city of Racine of receiving the bronze plaque awarded by the United States Chamber of Commerce for outstanding activities in health work,—first place in cities of class four being its standing.

—△—

Dr. V. W. Carlson, a graduate of the University of Minnesota 1929, is associated with Dr. M. G. Peterson, Lake Mills, in the practice of medicine. Dr. Carlson received his hospital training at the Letterman Hospital, San Francisco.

The American Board of Ophthalmic Examinations will hold an examination in New Orleans on Monday, May 9th, 1932, at the time of the meeting of the American Medical Association. Necessary applications for this examination can be procured from the Secretary, Dr. William H. Wilder, 122 South Michigan Ave., and should be sent to him at least sixty days before the date of the examination.

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Dr. Jay Marvin Salzman has opened offices at 1105 Sixteenth Street, Racine. He is a graduate of Washington University School of Medicine, St. Louis, 1929, and spent two years in the Jewish and Lutheran hospitals in that city as resident physician.

—△—

Dr. Clarence M. O'Hora, formerly of Excelsior, Wisconsin, has moved to Beaver Dam where he is occupying joint offices with his brother, Dr. J. A. O'Hora, dentist. Dr. O'Hora recently returned from an extended visit in the east during which time he attended clinics at Washington, Cleveland, and New York.

—△—

Dr. Frances A. Cline, Chicago, assumed the duties of maternity and infant physician on the staff of the Bureau of Child Welfare, State Board of Health, on November 23rd. Dr. Cline succeeds Dr. Eleanor Hutchinson who returned to similar work in Iowa.

—△—

Dr. W. C. Reineking, superintendent and medical director of Lakeview Sanatorium, Madison, spoke on "Tuberculosis" before a meeting of the Stoughton Rotary Club.

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Dr. Grant R. Curless, who has been occupying the office of Dr. H. E. Kasten during his absence in Europe, has opened an office in room 205 Public Service building, Beloit. He will limit the practice to internal medicine with special attention given to diseases of the heart.

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Dr. J. E. Stauffacher, formerly of Monroe, Wisconsin, and now leper worker at Inhambane, Portuguese East Africa, was the guest speaker of the Kiwanis Club of Madison on December 7th.

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District conferences of local health officers will be held during the winter in place of the customary biennial conference at Madison, it was decided at a recent meeting of the State Board of Health officials. Economy and the need for planning public health activities to meet varying conditions are the reasons for changing the conference arrangements.

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Dr. M. D. Cottingham of the Kohler Company medical department, addressed the Kohler Woman's Club at its regular meeting in December. His subject was "Acute Contagions." A discussion followed the talk.

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Mrs. Mary Ann Dean, 79, mother of Drs. Joseph and James Dean of Madison, died on December 3rd after several years of ill health.

The physicians, dentists, and druggists of Tomah enjoyed a six o'clock dinner at the cottage of Dr. A. E. Winter at Silver Lake recently.

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Dr. John M. K. Miles, New Orleans, has accepted a position at the St. Francis Hospital, La Crosse, where he will devote his entire time to pathology, laboratory and x-ray work. The laboratory department of St. Francis Hospital has recently been enlarged and new equipment added.

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Dr. G. T. Boyd, Fond du Lac, received minor bruises in an auto collision in front of his home. Dr. Boyd was driving away from the curb when hit by the other car.

—△—

Dr. Clarence E. Baeumle, Chicago, is occupying the office of the late Dr. R. B. Clark of Monroe. He is a graduate of Rush Medical College, 1929.

—△—

A $35,000 chapel and library addition to St. Luke's Hospital, Racine, which will be completed some time this month, is dedicated to three generations of a family of Racine physicians. The memorial is the gift of Dr. John G. Meachem, Jr., the remaining survivor of the family, and is intended to be the most complete hospital library in Wisconsin. The building will be open to the use of all physicians in the city. The library is the second important contribution to the hospital from the Meachem family. Dr. Meachem's father bequeathed $180,000 to the institution.

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Dr. and Mrs. A. Quisling, Madison, returned from Europe where Mr. Quisling took postgraduate courses in Berlin and Vienna. He is associated with his brother, Dr. Sverre Quisling, Madison.

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Dr. W. J. Meek, professor of physiology University of Wisconsin, was speaker on the program of the Radiological Society of North America meeting held in St. Louis on December 2nd.

—△—

Dr. C. S. Williamson, Green Bay, attended the annual meeting of the Western Surgical Society held in Denver early in December.

Dr. R. L. Troup, also of Green Bay, attended the Radiological Society of North American meeting at St. Louis.

—△—

Dr. John C. Docter, Racine, was speaker at the regular meeting of the child study group of the American Association of University Women of Racine. His topic was "Care of the Sick Child."

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Dr. H. M. Guilford, director of the bureau of communicable diseases, state board of health, gave an address on "Poliomyelitis" before the Minnesota State Public Health conference at St. Paul, December 14th.

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Dr. S. J. A. Francois, New Glarus, who was confined at a Madison hospital with pneumonia, has fully recovered.

The American Association for the Study of Goiter again offers an award of $300 for the best essay based upon original research work on any phase of goiter presented at the annual meeting in Hamilton, Ontario, Canada, June 14, 15, and 16, 1932.

Competing manuscripts must be in English and in the hands of the corresponding secretary, J. R. Yung, M. D., Rose Dispensary Bldg., Terre Haute, Ind., not later than March 15, 1932.

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Dr. H. F. Schroeder of Marinette received injuries consisting of two fractures of the right leg, three fractured ribs, and a gash in the head, as result of an auto accident on December 13th. He was returning to his home from a call when, in making a turn in the road, brushed another car being driven in the opposite direction and crashed into the ditch. The jolt threw Dr. Schroeder heavily against the car.

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The 1932 annual meeting of the Western Surgical Society will be held in Madison the first week in December. The meeting will bring surgeons from Seattle, Los Angeles, Denver, Chicago, Omaha and many other western cities, as well as a number of guests from the east and south. Dr. Arnold Jackson, Madison, has been named chairman of arrangements for the meeting.

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Dr. R. O. Settle, formerly physician in the Kansas state prison at Lansing, Kansas, has been appointed the new Wisconsin prison physician and assumed his new duties early in December. He has taken the place of Dr. L. S. Eagleburger, resigned.

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Dr. R. F. Sanders, formerly of Centerville, Indiana, has opened offices in Williams Bay. He served his internship at Ford Hospital, Detroit.

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Drs. Reginald and Arnold Jackson, Madison, attended the meetings of the Western Surgical Society held in Denver in December, and the Southern Surgical Society which met in White Sulphur Springs, W. Va. A paper on "Surgical Problems of Toxic Goiter" was given by Dr. Reginald at the Western meeting, and Dr. Arnold read a paper on "Primary Carcinoma of the Liver" (case report of partial left lobectomy) before the Southern meeting.

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Dr. John R. Goodfellow of Superior spent the holidays with his son-in-law, Dr. C. Oliver Heimdal of Aurora, Illinois. Dr. Heimdal is secretary and treasurer of the Aurora Medical Society and is a graduate of the University of Wisconsin.

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MILWAUKEE

At the annual meeting of the Vermont Club of Milwaukee held on December 5th, Dr. W. C. Partridge was elected president.

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The colleagues of Dr. Roland S. Cron, who has been ill for many weeks at Columbia Hospital, are happy to learn that Dr. Cron is improving daily.

Dr. G. Arthur Carhart was operated upon on December 8th, at Columbia Hospital, for a gall bladder affection. He was reported to be doing well.

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Dr. and Mrs. Charles H. Stoddard returned to Milwaukee the first of December after having spent Thanksgiving with their son, Frederick J., a student at the University of Michigan, Ann Arbor.

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Columbia Hospital, in anticipation of the enlargement of its x-ray department when its new addition is ready next spring, has added Dr. S. A. Morton, radiologist, formerly with the Mayo Clinic, to its staff.

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Dr. A. L. Banyai, of the Muirdale Sanatorium, sailed on December 2nd on the S. S. Mauretania for a cruise in southern waters, including visits in South America and Havana.

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The Educational committee of the Medical Society of Milwaukee County is again sponsoring free medical service to Goodfellow House, the Milwaukee Journal home for unemployed men, which opened on December 7th. The following members of the Society have generously cooperated in giving their services: Drs. W. P. O'Malley, Warren Tuft, E. J. Haberland, A. L. Suhr, Albert Popp, R. C. Schodron, Joseph Russell, R. D. Champney, Harvey E. Webb, C. H. Burnett, J. C. Griffith, Maurice Kretchmar, Jack Kinsey, Max E. Wiese, Anthony Kult, and Ralph T. Rank.

Dr. Robert W. Blumenthal is chairman of the educational committee and has been on duty at the Goodfellow House every day since it opened, supervising the examinations of the men living there. He was assisted by Drs. A. J. Patek and C. C. Schneider, members of the committee.

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Dr. Theodore L. Squier, head of the medical department of the A. O. Smith Corporation, was appointed a member of the Shorewood Village Health Board on December 8th. Dr. Squier will fill the unexpired term of Dr. T. L. Szlapka, who resigned on account of illness.

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According to a report of Dr. J. P. Koehler, Milwaukee health commissioner, more than 33,000 children have been immunized against diphtheria since the drive began early in the year 1931.

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Through the joint efforts of Dr. John Arthur Wilson and Dr. Stanley Seeger an improved method of treating severe burns, especially among children, is being developed. Dr. Seeger, for some time past, has been active in a campaign to prevent burns among Milwaukee children.

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The first of a series of postgraduate courses, sponsored by the educational committee of The Medical Society of Milwaukee County,—Diseases Of The Nervous System,—is now underway with fifty enrolled. Small groups have been assigned to the following Society members who are instructing this course: Drs. John L. Garvey, Merle Q. Howard, H. W. Powers, Andrew I. Rosenberger, and Frank C. Studley.

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Dr. and Mrs. William Jobse left on December 10th for Pharr, Texas, where they will be the guests of their daughter, Mrs. A. W. Hahn, for the next three months.

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Dr. Harvey E. Webb, a member of the Speakers' Bureau of The Medical Society of Milwaukee County, spoke to the Parent-Teacher Association of the Palmer School on Wednesday evening, December 9th. His subject was "Normal Living."

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Dr. E. L. Miloslavich, director of the department of clinical pathology and medical research at St. Mary's Hospital, addressed the Kiwanis Club at Stevens Point, on June 16, on "Criminal Pathology". In the evening of the same day, he discussed "Industrial Pathology" at the joint meeting of the Portage County Medical Society and St. Michael's Hospital medical staff, at that city. On July 23, the subject of his talk to the Rotary Club at West Allis was "Criminal Pathology with Special Reference to Sadistic Murder".

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The following health talks, sponsored by the State Board of Health, and delivered by Mr. Theodore Wiprud, executive secretary of The Medical Society of Milwaukee County, will be broadcast over The Milwaukee Journal Station, WTMJ, during the month of January:

January 8—Pneumonia as a preventable disease.
January 15—Rejuvenation: fact or fancy?
January 22—Erysipelas and blood poisoning.
January 29—Good posture—to have and to hold.

—△—

Dr. and Mrs. Arthur T. Holbrook returned to Milwaukee on December 21st from Milton, Massachusetts, where they attended the wedding of their son, Arthur Andrew Holbrook, and Miss Susan Miller Dette.

The bridegroom will finish his medical training at the Harvard University Medical School with the class of June, 1932.

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Dr. Stanley J. Seeger left on December 22nd for Texarkana, Texas, to join Mrs. Seeger and the children for the Christmas holidays.

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At the Annual Meeting of the Board of Directors of the Marquette Medical Alumni Association, held at the Milwaukee Athletic Club on December 13th, Dr. Leander J. Foley was elected president of the Association and Dr. Robert E. Fitzgerald, treasurer.

—△—

The second meeting of the Woman's Auxiliary to The Medical Society of Milwaukee County will be held at the Hotel Astor on Friday, January the 8th, at 12:30 P. M.

Dr. Robert W. Blumenthal, chairman of the Educational Committee of the Society will address the group on the relation of the medical profession to the public.

The charter membership roll will be closed after this meeting.

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Dr. F. R. Janney and Dr. D. W. Roberts will represent the Speakers' Bureau of The Medical Society of Milwaukee County during January. On January 6th, Dr. Janney will address the Parent-Teacher Association of the Roosevelt School, Wauwatosa, on health of school children.

Dr. Roberts has been invited to address the parents of the children of first-grade age at the Milwaukee State Teachers' College on January the 26th. His subject will be mental hygiene of childhood.

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Members of the staff of St. Luke's Hospital have suggested to the Lutheran Hospital Association that an addition to the hospital be given their serious consideration. Dr. W. J. Carson pointed out the need for a wing to include a modern operating room, and proposed other facilities. Other speakers, at a luncheon held in the Hotel Schroeder early in December, were Drs. E. L. Tharinger and H. J. Gramling.

Special studies of cancer are to be made by a committee of physicians at St. Luke's. This committee consists of Drs. W. J. Carson, Chairman, E. L. Tharinger, J. Edwin Habbe, Joseph Gramling, and Henry J. Olson.

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The Educational Committee of The Medical Society of Milwaukee County will sponsor a round table conference for Milwaukee hospital interns during 1932. Problems confronting the young practitioner just entering practice will be discussed. Discussions will be led by older Society members who will endeavor to assist these beginning physicians by imparting to them knowledge gained by long years of experience.

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At a meeting of the Committee on Collection Service, held in the Mariner Tower on December 8th, Mr. Gramling, manager of The Medical Business Bureau, reported the progress of the Bureau.

Ways and means of bringing about a closer cooperation between members of the Society and the Bureau, and of securing new subscribers to the Bureau were discussed; also means of giving all possible aid to subscribers were considered.

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At a meeting of the Board of Directors, held in the Mariner Tower on December 11th, the following physicians were elected to membership in The Medical Society of Milwaukee County:

By transfer—Dr. Earl C. Quackenbush; senior membership—Dr. Max E. Wiese; junior membership —Dr. Paul E. Aszman, Dr. C. D. Jurss and Dr. Leonard C. J. Olsen.

The following committees for 1932 were appointed by President-Elect P. M. Currer and approved by the Board of Directors of The Medical Society of Milwaukee County at their meeting held on December the 18th:

HEALTH COUNCIL

Ralph P. Sproule, Chairman

R. W. Blumenthal__1932	Millard Tufts_____1934
H. J. Gramling____1933	W. F. Grotjan_____1935

Sub-Committees of the Health Council

Educational Committee

R. W. Blumenthal, Chairman

A. J. Patek	C. C. Schneider
S. M. Markson	Harvey E. Webb

Child Welfare and Public Nursing Committee

Millard Tufts, Chairman

H. O. McMahon	H. B. Miner
J. F. Shimpa	John McCabe

Health Department Advisory Committee

H. J. Gramling, Chairman

G. H. Fellman	J. F. Zivnuska
L. P. Stamm	E. F. Cook

Committees

Physicians' Service Bureau Membership Committee

N. E. McBeath, Chairman

W. A. Ryan	Jos. Russell
S. E. Kohn	R. E. McDonald

Legislative Committee

G. E. Seaman, Chairman

Dexter Witte	J. Gurney Taylor
F. D. Murphy	Bernard Krueger

Social Committee

H. O. Zurheide, Chairman

R. H. Frederick	A. H. Lahmann
C. W. Long	W. W. Hume

Physicians' Service Bureau Advisory Committee

A. R. F. Grob, Chairman

Chas. Baugh	A. R. Langjahr
R. W. Garens	S. R. Mitchell

Program Committee

H. C. Schumm, Chairman

E. L. Baum	W. J. Egan
J. W. Truitt	E. O. Gertenbach

Membership Committee

Mark Bach, Chairman

John L. Garvey	W. J. Carson
Irwin Schulz	A. M. Dorr

Committee on Collection Service

C. M. Echols, Chairman

John W. Powers	R. A. Toepfer
A. H. Knudson	S. L. Krzysko

Social Medicine and Medical Economics Committee

S. J. Seeger, Chairman

W. M. Kearns — Charles Fidler
J. C. Griffith — Edwin B. Gute

Grievance Committee

E. L. Tharinger, Chairman

C. W. Eberbach — E. F. Peterson
R. E. Fitzgerald — Fred A. Stratton

The Milwaukee Medical Times

S. J. Seeger, Editor
Mr. Theodore Wiprud, Managing Editor

—△—

The health council of The Medical Society of Milwaukee County, of which Dr. Ralph P. Sproule is chairman, is sponsoring a plan whereby persons employed in eating places will be examined. The Council has approached one of the largest restaurant owners in Milwaukee for the purpose of securing his cooperation in having all food handlers in his restaurants examined. He heartily endorsed the Council's plan and agreed to cooperate with them in every way possible.

The Council will set up a plan as to the type of examinations, and when food handlers are examined a certificate to that effect will be given to the owner or manager, showing that all employees of his establishment have been examined. The examination will be made by physicians in good standing, selected by employers or employees.

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Letters have been directed to medical staffs of Milwaukee hospitals inviting them to select a member of their staff to represent their hospital in a committee sponsored by The Medical Society of Milwaukee County for the purpose of considering problems affecting the medical profession of Milwaukee County.

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Dr. Michael W. Shutkin is at present doing postgraduate gastroenterology work in Vienna. From Vienna he will go to Frankfort on the Main. He will return to Milwaukee in spring or early summer to begin specialized practice in gastrointestinal diseases.

BIRTHS

A son to Dr. and Mrs. S. H. Wolter, Milwaukee, on December 14th.

A daughter to Dr. and Mrs. Elmer Gramling, Milwaukee, on December 17th.

A daughter to Dr. and Mrs. J. S. Supernaw, Madison, on December 8th.

A son, Richard Harold, to Dr. and Mrs. L. D. Quigley, 1025 Emilie St., Green Bay, November 15th.

A daughter, Mary Rita, to Dr. and Mrs. R. S. Fisher of Allenton on December first. Mrs. Fisher was formerly Miss Ramona Seeboth and a graduate of the Milwaukee County Hospital.

DEATHS

Dr. Harold B. Anderson, Beloit, died on November 26th, 1931, at the home of his brother in Janesville.

Dr. Anderson was born in Chicago in the year 1865 and graduated from the University of Illinois College of Medicine in 1884. He began his practice in Orfordville where he remained for nearly thirty years. In 1910 he moved to Beloit.

Dr. Anderson was a member of Rock County Medical Society, the State Medical Society, and the American Medical Association.

He is survived by his brother and one sister, both of Janesville.

Dr. Fremont E. Chandler, Waupaca, died suddenly on December 5th, 1931, of a heart attack.

He was born in Waupaca in 1861 and was a graduate of the University of Wisconsin and Rush Medical College. Following graduation, he practiced in Chicago until 1916 and then moved to Waupaca. Dr. Chandler had started his third term as mayor of the city of Waupaca.

Dr. Chandler was a member of Waupaca County Medical Society, the State Medical Society, and was a fellow of the American Medical Association.

He is survived by his widow, two daughters, and three sons, Dr. F. A. Chandler, Chicago; William Chandler, basketball coach at Marquette University, and Dr. Edwin Chandler, dentist at Waupaca.

Dr. Edward J. Fucik, Williams Bay, died on December 1, 1931.

He was born in the year 1879 and was a graduate of the University of Illinois College of Medicine in 1903. He had practiced in Williams Bay for thirty years. He was a director of Elkhorn State Bank and served as president of the Walworth County Medical Society.

Dr. Fucik was a member of the Walworth County Medical Society, the State Medical Society, and was a fellow of the American Medical Association.

He is survived by his widow.

Dr. Levi N. Hicks, Burlington, died on November 29th at his home in Burlington. He had been an invalid for several years.

Dr. Hicks was born on February 25, 1851, in Sacramento, California, and came with his parents to Wisconsin when he was very young. He graduated from Rush Medical College in 1878 and practiced for two years in Spring Prairie. He then moved to Burlington where he practiced for more than fifty years.

He mas a member of Racine County Medical Society, the State Medical Society, and the American Medical Association.

He is survived by his widow.

Dr. W. E. Fawcett, formerly of Bayfield, Wisconsin, died on December 12th at his home in Bushnell, Ill.

He was named superintendent of Pureair Sanatorium, Bayfield, in 1923 remaining with that institution for four and one-half years. Leaving Bay-

field in the spring of 1928, Dr. Fawcett joined the staff of Michigan State Sanatorium at Howell, Michigan. Last March, he was appointed superintendent and medical director of Elm Grove Sanatorium at Bushnell, Ill.

While in Wisconsin, Dr. Fawcett was a member of Ashland-Bayfield-Iron County Medical Society.

He is survived by his widow and three daughters.

Dr. H. G. Mertens, Bayfield, died on December 8th, 1931, following a second heart attack, which he had suffered in a week.

Born in Germany in 1875, Dr. Mertens came to this country at the age of eight, first settling in Neenah. He then came to Ashland where he worked for the Chicago and Northwestern Railway Company as weighmaster. He attended Northland College for two years and then took up the study of medicine at the Physicians and Surgeons Medical College at Chicago. He graduated from Vanderbilt University, Nashville in 1900. For a time Dr. Mertens practiced in both Ashland and Washburn, and for the past twenty-two years resided in Bayfield. He served as mayor of Bayfield, and was chairman of the town of Bayfield. He saw service in the Spanish American War and served as captain of the medical corps in the World War. At the time of his death, he was commander of the local post of the American Legion.

Dr. Mertens was a member of the Ashland-Bayfield-Iron County Medical Society, the State Medical Society, and the American Medical Association.

He is survived by his widow and three daughters.

Dr. W. N. Nolan, Kaukauna, died on October 17th, following a two years' illness.

Dr. Nolan was born in Grand Chute, Wisconsin, in 1870. He was a graduate of Rush Medical College in 1894, and served as city physician of Kaukauna until five months ago.

He is survived by his widow.

Dr. G. H. Perrin, Menomonee Falls, died on October 16th. He had been ill for the past year.

He was born in the year 1864 and was a graduate of Keokuk Medical College, Keokuk, Iowa, in 1892.

Dr. Perrin was a member of the Waukesha County Medical Society, the State Medical Society, and was a fellow of the American Medical Association.

Dr. C. V. Porter, Viroqua, died on November 30th.

Dr. Porter was born in Maine in 1849 and came to Vernon County as a teacher in his youth. He worked his way through the University of Michigan Medical School by teaching, and graduated in 1875. He returned to Viroqua after practicing at Lansing, Iowa, and Mount Sterling, Wisconsin. For many years he had made the study of Vernon County history a hobby and was instrumental in having a number of markers erected at historic spots along the county highways.

He is survived by his son, Charles, who lives at Barron, Wisconsin.

Dr. W. P. Salbreiter, Racine, died on Saturday, December 12th, at his home. He had been in ill health for several weeks.

Dr. Salbreiter was born in the year 1880, and was a graduate of Milwaukee Medical College in 1907. He served in the Thirty-Second Division, first as a lieutenant in a Racine Ambulance Company at Camp Arthur, Texas, and later as captain with the Division's Sanitary Corps. Dr. Salbreiter was a survivor of the Tuscania disaster when the troop ship was sunk in 1917.

He was a member of Racine County Medical Society, the State Medical Society, and was a fellow of the American Medical Association.

He is survived by his widow.

SOCIETY RECORDS

New Members

A. A. Cantwell, Shawano.

F. S. Wasielewski, 905 W. Lincoln Ave., Milwaukee.

R. I. Hiller, 208 E. Wisconsin Ave., Milwaukee.

Elsa Edelman, 759 N. Milwaukee St., Milwaukee.

F. R. Farrell, 2905 W. Clybourn St., Milwaukee.

C. H. Burnett, 161 W. Wisconsin Ave., Milwaukee.

A. C. Hansen, 238 W. Wisconsin Ave., Milwaukee.

S. E. Coffey, 3208 W. Clybourn St., Milwaukee.

D. C. Ausman, 2524 W. Keefe Ave., Milwaukee.

Urban E. Gebhard, 1332 So. 16th St., Milwaukee.

M. C. Canan, 2003 Winnebago St., Madison.

Changes in Address

F. E. Kosanke, Fond du Lac to Lomira.

F. F. Zboralski, Manitowoc to 810 E. Center St., Milwaukee.

C. M. O'Hora, Excelsior to 106½ Front St., Beaver Dam.

Robert Krohn, La Crosse to Black River Falls.

H. A. Shearer, Edgerton to 208 Public Service Bldg., Beloit.

Contribution of approximately 150 pints of blood from 161 qualified donors resulted in substantially checking the ravages of the recent infantile paralysis epidemic, according to Dr. W. D. Stovall, director of the State Laboratory of Hygiene.

Through December sixth the number of cases totaled 711. The infantile paralysis epidemic reached larger proportions in 1931 than in any previous year in the history of the state, but the after-effects have been greatly lessened through the wide use of convalescent serum.

Use of convalescent serum in the treatment of infantile paralysis was initiated in Wisconsin last summer. Experiments in other states proved the efficacy of the serum and when the first signs of the approaching epidemic became apparent during the middle of the summer, Dr. C. A. Harper, through the Wisconsin General Hospital sent out a statement to the effect that the State Laboratory of Hygiene would pay $25 for each pint of blood donated by individuals who had had infantile paralysis. In addition, traveling expenses of donors were paid to and from Madison.

People from all over the state responded, and the quantity of the blood received, although only half is actually converted into serum, was sufficient to supply almost all demands for the serum.

Sixty-three of the state's 71 counties felt the epidemic, records of the state laboratory show. Although a sharp decline in new cases has followed the arrival of cold weather, the State Laboratory will keep a supply of the polio serum on hand throughout the winter.

* * *

Of the 8,765 students registered at the University of Wisconsin in the fall of 1931, 1,810 are entirely self-supporting, announced the university statistician. This amounts to about 23 per cent of the entire student body. Of the 1,810 self-supporting students, 1,392 are men and 418 are women.

The statistics are based on replies from 7,889 students who answered the question on registration cards at the beginning of the semester.

* * *

Alcohol was given as the cause of only 11 deaths during the third quarter of 1931, the lowest toll from this cause recorded in any quarter since 1923, it was announced by the bureau of vital statistics, state board of health.

The alcoholism death list for the first three quarters of 1931, however, reached a total of 106, three more deaths than occurred during the whole of 1930, records of the bureau show. Deaths from this cause during the first quarter of 1931 totaled 40 cases and during the second quarter 55, the latter marking the greatest quarterly toll during the past eight years.

Wisconsin deaths of which alcoholism was recorded as the cause have averaged 101 annually during the past seven years. This figure, however, does not present a complete picture of the effects of excessive alcohol consumption, the state board points out, for the reason that alcohol may be a contributing factor in many deaths ascribed to cirrhosis of the liver, tuberculosis, pneumonia, and other diseases.

* * *

Horses and horse-drawn vehicles caused 16 deaths in Wisconsin during the first eight months of 1931, while only six persons lost their lives in aeroplane accidents during the period.

* * *

X-ray examination of athletes has thus far failed to show that they have enlarged hearts, Dr. Walter J. Meek, professor of physiology of the University of Wisconsin Medical school said at the 17th annual meeting of the Radiological Society of North America.

"There is common belief," Dr. Meek said, "that athletes have enlarged hearts, but there has been no sufficient study of the matter so far as we are aware." Dr. J. A. E. Eyster has secured a large series of observations on Wisconsin athletes. The subjects include 83 men and 84 women, all of whom have indulged in athletics throughout their high school course and two or more years in college. "On comparing the x-ray pictures of this group with the pictures of one hundred normals, there is no variation from the normal and therefore no evidence of hypertrophy."

» » » CORRESPONDENCE « « «

Five Dollars Fee

12 December 1931.

Dr. -- -- --------,
Wisconsin.
Dear Doctor --------:

You ask if there is any provision in the law governing admissions to the Wisconsin General Hospital which provides for payment to the physician for the examination of the patient.

Subsection 2 of Section 142.03 provides that the Judge shall appoint a physician personally to examine the person and that such physician shall make a verified report in writing, "setting forth the nature and history of the case, and such other information as will be likely to aid in its treatment, and giving his opinion whether the condition of the person can probably be remedied, or should be treated, at a hospital, and whether the person can receive adequate treatment in the county, at home or in a hospital, and any information within the knowledge of the physician relative to his financial situation. The physician shall be paid by the county, five dollars, and actual and necessary expenses."

If I can afford additional information, please do not hesitate to call upon me.

Cordially yours,

J. G. CROWNHART,
Secretary.

Costs of Service to Counties at Wisconsin General Hospital and Local Care Provision Outlined to County Judges

At the suggestion of the State Medical Society and in cooperation with it, Dr. R. C. Buerki, Superintendent of the Wisconsin General Hospital, addressed each of the County Judges in the state during December to outline services and costs at the state institution. The letter was carefully prepared that the County Judges might have a clear understanding of the provisions for local care under Chapter 80, Laws of 1931, and to indicate, by one illustration, the savings that might thus obtain for the County.

The letter follows:

December 2, 1931.

Judge -- -- --------,
Wisconsin.
Dear Judge --------:

The question has recently been raised by several of the county judges, as to the cost of care for county cases in the State of Wisconsin General Hospital, how it is billed, and what the charge includes. The total cost for the hospital care is billed to the state, who in turn bill one-half to the county. The hospital bills the state $4.76 a day ($2.38 to the state and $2.38 to the county) for all cases admitted to the hospital, with the following exceptions: the charge in the new Children's Orthopedic Hospital is $4.76 a day ($2.38 to the state and $2.38 to the county) for the first month and $3.50 ($1.75 to the state and $1.75 to the county) for any time over a month the patient may be confined to the hospital. In addition, waiting maternity cases are billed at the rate of $1.00 a day ($.50 to the state and $.50 to the county). All of these charges are inclusive. The patient may, if we deem his condition demands it, receive a special room and a special nursing service under this cost. There is no extra charge for operations or professional work. The physician's service is given to the patient by the teachers who receive salaries from the Medical School. In addition, we estimate that the counties pay transportation to Madison for about 15% of the cases, which is an added charge to the county.

We find that in some cases we have kept the patients in the hospital several days waiting for a brace or other special bit of apparatus, where the cost of hospital care to the county has much exceeded the cost of appliance. Therefore, wherever possible, we are now treating these cases in the outpatient department and billing the counties directly for any special brace or x-ray required. Under the law, this cost cannot be divided jointly by state and county. In almost all instances, the cost is materially less than would be charged if the patient had to stay in the hospital for a period of days, waiting for the brace or special work.

We think that the Wisconsin General Hospital should be utilized for the care of patients who need care at public expense and who can be treated there with greatest advantage to themselves and at the least relative cost to the public, but not for patients who can be cared for equally well and at the same or less expense at home. Under Chapter 80, Laws 1931. For instance, it is frequently disadvantageous to send a minor for a tonsillectomy when the cost of transportation or cost of sending a guardian will more than offset the cost of having the operation performed locally. This statute gives patients and judges some choice in hospital selection. It also defines pre-requisites for hospitalization of orthopedic patients.

To summarize then, the cost of hospitalization here, is in the main, $4.76 a day of which the county is billed for $2.38 and the general funds of the state a like sum. The general State funds thus utilized come in the main from taxes upon public utilities and from income taxes and similar sources, which while not a direct charge against the county, adds to the total taxation.

Under the present statutes, (Sec. 142.09, Wis. Stats.) when a patient cared for as a state patient is at the time or subsequently able to pay for a part or the whole cost of such care the county can collect from the patient and remit to the state its half of the payments thus made.

If there are any other questions relative to the hospital that you may have, please let us hear from you.

Sincerely,
R. C. BUERKI, M. D.
Superintendent.

RCB/C

ATTORNEY GENERAL'S RULINGS

Two rulings on questions relating to local care of what would otherwise be state hospital patients, were made by the Attorney General's Department recently. While holding that the department was without power to issue formal opinions to the County Judge on questions arising in interpretation of the law, the Department made the following informal statements:

October 20, 1931.

Walter A. Graunke,
District Attorney,
Wausau, Wisconsin.

You inquire whether under ch. 142 of the statutes as amended by ch. 80, Laws 1931, the cost of transportation of the patient to the Wisconsin general hospital is to be added to "one-half the per diem hospital charge in determining whether the patient 'can re-

(Continued on page 58)

"Unaccustomed as I am to Public Speech"

By H. L. EWBANK, Ph. D.
Associate Professor of Speech
University of Wisconsin, Madison

To thousands of men and women whose education did not include training in public speaking these words, echoing in banquet halls and meeting rooms from Kennebunk to Red Gulch, arouse poignant memories. They follow a period of mental panic and scattered preparation on the part of the speaker and precede a period of more or less acute discomfort for speaker and listener alike.

"Why, O why," groans the speaker to himself as he mops his brow and gulps a glass of ice water, "did I let myself in for this thing?" And, "Why, O why," sighs the chairman of the program committee, "do you suppose Mr. Blank, who is so well informed and charming in conversation, acts like a bashful boy on the brink of his first proposal when he tried to make a speech?"

Because Mr. Blank has practised conversation until he is sure of his ability to speak interestingly and to the point. Because he is confident that words will come and fairly sure that he will make a good impression. But it was not always so. Time was when the charming conversationalist grew sick at heart at the very thought of sitting next to that intelligent Mrs. Jones at dinner, or of exchanging a few words with the learned visiting specialist, for fear they would think him dull and provincial. He was a victim of stage fright, that fearful feeling in the front of the back that seizes great and small alike when they are doubtful of their ability to make a good impression and can't decide whether to run or stay and face the music.

And how did he conquer that fear as far as conversation is concerned? It would be nice if there were a secret that could be imparted in three easy lessons. But there isn't. His poise in conversation came from continued practice, even from thinking out in advance what he might talk about; it came from careful analysis of successful conversationalists and frank imitation of their methods. Then why can't he overcome his fear of making public speeches in the same way? He can if he wants to and is willing to take the trouble.

But why should medical men learn to speak in public? That, I suppose, is a question for you to answer. The other evening at a dinner party the talk veered round to the importance of being able to make a passable public speech. A physician of considerable distinction spoke up. "It would be worth $25,000 to me," he said, "to be able to give a good clear statement of my research at medical meetings, and to be able to talk convincingly on health topics to lay audiences." Another doctor voiced his agreement. "But, of course," he added, "it is a well known fact that doctors are the poorest speakers in the world."

"Hold on,"—I broke into the discussion at this point—"you are taking in a lot of territory. Not so long ago, an engineer claimed that doubtful distinction for his profession. And I have even heard the same claim for school teachers, especially college lecturers."

But my medical friends were not so easily sidetracked. They continued to make the point that doctors are, as a class, not conspicuous successes, either as lecturers to colleagues or as speakers before groups of laymen. The lawyer, the minister, the statesman form public opinion largely because of their ability to speak in public; the doctor, with knowledge that is just as vital, and often with more information on the point at issue, too often remains silent and the community is led by lesser lights. Moreover, articles written by laymen, and dealing with medical costs, medical ethics, and the possible advantages of state medicine, are beginning to appear in our magazines; while the same sentiments are finding expression in addresses and lectures. The case for the medical profession should be presented by members of that profession, rather than by ghost writers and professional speakers, who, no matter how hard they try, can only present an outsider's point of view.

This was the argument presented at the dinner party and similar sentiments were echoed by members of the Milwaukee

(Continued on page 58)

PRESS SERVICE OF STATE MEDICAL SOCIETY

No serum does so much for public health as printer's ink

MEASLES

Madison, Wis., Dec. 3—Measles may be a disease common to school children but it carries with it greater dangers to future health than any other child ailment. Because of the large increase in the number of cases of measles in Wisconsin during the past summer, an increase of 891 in one single month, the Educational Committee of the State Medical Society warns mothers to be on the watchout for other infirmities and illnesses developing later as a result.

"Of all of the communicable diseases, measles is one of the most contagious," declares the Medical Society's Health Bulletin. "Practically every child between the ages of six months and ten years who has not previously had the disease develops measles following exposure to it. It is this very great susceptibility of children that makes its spread so difficult to prevent. The actual spread of the disease is usually by direct contact, but it is not at all necessary for the contact to be real close, because being in the same room for only a short time is usually enough to infect the susceptible child.

"Starting as it does, with the symptoms of a cold and cough, lasting for several days before the rash appears, it is more often than not unrecognized until any number of children have been exposed. Many an epidemic of measles has been started by a thoughtless mother who could not be bothered to keep her children from school because of what seemed to be a slight cold. It is this stage of 'coming down' with measles that the disease is most contagious, although it continues to be so throughout the course of the disease. In addition to direct contact with the patient, the disease is spread by contact with articles freshly soiled by secretions from the nose and throat of the child with measles. Thus towels, handkerchiefs, and eating utensils may be responsible for its spread. Also persons coming directly from the patient may carry the infection from room to room in the same building, but it is not likely that a third person can carry the infection through fresh air from one building to another.

"For some strange reason the public at large used to regard measles as a trivial disease. As a consequence the death rate would average three to six per cent from year to year and some years would run at a much higher level. During the past ten years, however, an appreciation of the seriousness of measles has come about and the death rate has steadily fallen from year to year. Out of 22,820 cases of measles in Wisconsin in the year 1930, there were only 99 deaths, as compared to 89 deaths from scarlet fever out of 5,760 cases.

"Measles is particularly dangerous to life in children under four years of age, and between 90 and 95 per cent of all deaths from measles occur in that age period. In young children complications such as broncho-pneumonia and abscessed ears are frequent and many other complications, the most serious of which is sleeping sickness, sometimes occur. The older the child and the better the individual care the less apt are complications to develop. Another serious characteristic of measles is the increased susceptibility of other contagious diseases, particularly diphtheria, erysipelas and whooping cough. Measles also seems to have a definite tendency to arouse latent tuberculosis and to increase the susceptibility to tuberculosis. For these various reasons, it may be readily seen that measles is a serious disease to health and life that every case should be given the most careful medical and nursing supervision."

BEHAVIOR OF CHILDREN

Madison, Wis., Dec. 10—Children do not inherit bad conduct nor the unfavorable traits of their parents. The mother who spends her time worrying about her daughter may be so strict as to develop elements of conduct more dangerous than any she fears.

"Misbehaving children generally acquire their bad behavior from influences in their surroundings rather than through inheritance," declares the Educational Committee of the State Medical Society in a bulletin issued today. The bulletin points out that bad habits do not develop suddenly, but as the result of a long series of unfavorable influences.

"In bringing up children it is fairly safe to assume that they have more than an even chance of developing into useful and capable men and women if they are given the proper opportunity," declares the bulletin. "Some are more intelligent and more ambitious than others. Some may be born with sensitive natures, nervous temperaments or other disabilities but these traits may exist regardless of what the parents are.

"This fear of bad heredity may cause much mischief. Often the mother watches the boy too carefully. She is on the lookout for unfavorable traits and she half expects him to steal or lie. The result is that she is far too strict with him, too free with warnings and admonitions. The child is tempted to try the very things she urges him to avoid. Unfavorable traits are often brought out in children by this kind of mismanagement.

"When there has been mental disease in the family, parents often fear that the children will inherit the disorder. There are very few families in which there has not been a case of mental disease of one form or another. Children from families where such cases have existed are not much more likely to develop mental troubles than other children. Unnecessary worry and unhappiness have come because this fact has not been understood. Many mental diseases occur as a result of faulty mental hygiene regardless of how good the inheritance may be. Healthy, normal surroundings contribute greatly to mental health. These factors are of much more significance in the lives of children than is any supposedly inherited taint.

"Parents should not regard misconduct necessarily as inherited or as something in the child which is to be controlled by punishment. It is generally a sign of unfavorable factors either in the physical condition of the child or in the surroundings at home or in school."

PNEUMONIA

Madison, Wis., Dec. 17—When Wisconsin people are able to fight off the flu, the death rate from pneumonia declines. In recent years the toll from pneumonia has been lower than cancer and heart disease, but when flu strikes the country it rises like a sky rocket. Outside of Wisconsin, pneumonia is one of the most frequent causes of death and yearly in the United States exacts a toll of 100,000 lives.

The Educational Committee of the State Medical Society in a warning issued today declares that people should be especially careful when the weather changes from day to day. The report declares that with pneumonia there is a tendency toward complications, such as lung abscess, abscess of the pleura, damaged hearts

(Continued on page 56)

THE JOURNAL BOOK SHELF

Modern Proctology. By Marion C. Pruitt, M. D., L. R. C. P., S. (Ed.), F. R. C. S. (Ed.), F. A. C. S., Atlanta, Ga. Associate in surgery, Emory University School of Medicine; assistant visiting surgeon, Grady Hospital; Proctologist, Crawford W. Long Memorial Hospital, and Clinic, Georgia Baptist Hospital, and Anti-Tuberculosis Association. With 233 illustrations. Price $8.00. C. V. Mosby Company, St. Louis, Mo. 1931.

The Letters of Dr. Betterman. By Charles Elton Blanchard, M. D. Medical Success Press, 36 N. Phelps St., Youngstown, Ohio. 156 pages, price $1.00.

Collected Papers of the Mayo Clinic and the Mayo Foundation. Volume XXII. Edited by Mrs. Maud H. Mellish Wilson, Richard M. Hewitt, B. A., M. A., M. D., and Mildred A. Felker, B. A. Octavo volume of 1125 pages with 234 illustrations. Philadelphia and London: W. B. Saunders Company, 1931. Cloth, $13.00 net.

Simple Lessons in Human Anatomy. By C. H. Harvey, M. D., professor of anatomy, University of Chicago. Illustrated. American Medical Association, Chicago.

Accidental Injuries. The Medico-Legal Aspects of Workmen's Compensation and Public Liability. By Henry H. Kessler, A. B., M. D., F. A. C. S.

The Practice of Medicine. By A. Stevens, A. M., M. D., professor of applied therapeutics in the University of Pennsylvania; visiting physician to Philadelphia General and University Hospitals; consulting physician to St. Agnes' Hospital, Philadelphia. Third edition, entirely reset. 1150 pages, illustrated. Philadelphia and London, W. B. Saunders Company, 1931. Cloth $8.00 net.

Clinical Laboratory Methods. By Clyde L. Cummer, Ph. B., M. D., F. A. C. P., formerly associate clinical professor of clinical pathology. School of Medicine, Western Reserve University, Cleveland; instructor in dermatology and syphilology, School of Medicine, Western Reserve University, visiting dermatologist, Charity and St. Alexis Hospitals, Cleveland. Third edition, thoroughly revised. Illustrated. Price $6.75. Lea & Febiger, Philadelphia, 1931.

Gonorrhea in the Male and Female. By Percy S. Pelouse, M. D., associate in urology and assistant genito-urinary surgeon at the University of Pennsylvania; fellow of the Philadelphia College of Physicians, Philadelphia. Second edition, revised. 440 pages with 92 illustrations. W. B. Saunders Company, Philadelphia and London. Cloth $5.50 net. 1931.

Surgical Pathology of the Genito-Urinary Organs. By Arthur E. Hertzler, M. D., surgeon to the Agnes Hertzler Memorial Hospital, Halstead, Kansas; professor of surgery, University of Kansas. 222 illustrations. J. B. Lippincott Company, Philadelphia.

Approved Laboratory Technic. Prepared under the auspices of The American Society of Clinical Pathologists by John A. Kolmer, M. D., Dr. P. H., professor of pathology and bacteriology, Graduate School of Medicine, University of Pennsylvania; professor of immunology and chemotherapy, School of Medicine, Temple University; head of Department of Pathology and Bacteriology, Research Institute of Cutaneous Medicine; and Fred. Boerner, V. M. D., associate professor of Bacteriology, Graduate School of Medicine, University of Pennsylvania. With 11 colored plates and 300 illustrations. D. Appleton & Company, New York. 1931.

Diseases of the Thyroid Gland. By Arthur E. Hertzler, M. D., surgeon to the Halstead Hospital. With a chapter on Hospital Management of Goiter Patients by Victor E. Chesky, M. D., associate surgeon to Halstead Hospital. Second edition, entirely rewritten. Cloth $7.50. C. V. Mosby Company, St. Louis, 1929.

BOOK RECEIVED FOR REVIEW

Conquering Arthritis. By H. M. Margolis, M. D. Price $2.00. The Macmillan Company, New York, 1931.

Emergency Surgery. By John William Sluss, A. M., M. D., F. A. C. S. Associate professor of surgery, Indiana University School of Medicine; zone surgeon, United States Fidelity and Guaranty Company; consulting surgeon, City Hospital, and John Walter Martin, M. D., assisted by David Hart Sluss, M. D., and Camilius B. DeMotte, M. D. Fifth edition, revised and enlarged. 797 illustrations, some in colors. Price $5.00. P. Blakiston's Son & Co., 1012 Walnut St., Philadelphia.

Living the Liver Diet. By Elmer A. Miner, M. D., Independence, Kansas. With introduction by William P. Murphy, M. D., instructor in medicine at Harvard Medical School, Boston. Price $1.50. C. V. Mosby Company, St. Louis, Mo. 1931.

Health Protection for the Preschool Child. A national survey of the use of preventive medical and dental service for children under six. A publication of the White House Conference. Price $2.50. The Century Co., 353 Fourth Avenue, New York, N. Y. 1931.

Allergy And Applied Immunology. A handbook for physician and patient on asthma, hay fever, urticaria, eczema, migraine and kindred manifestations of allergy. By Warren T. Vaughan, M. D., Richmond, Va. Illustrated. Price $4.50. C. V. Mosby Co., 3523 Pine Blvd., St. Louis, Mo.

BOOK REVIEWS

Any scientific publication reviewed in this column may be obtained for inspection. Orders for such inspection should be directed to the Medical Library Service, 424 N. Charter Street, Madison, Wis.

Diathermy. Its production and uses in medicine and surgery. By Elkin P. Cumberbatch, M. A., Medical officer in charge, electrical department, St. Bartholomew's Hospital. Second edition, Price $7.00. C. V. Mosby Co., St. Louis, 1928.

The writer finds that the author of this text has embodied the experiences and practices of electrotherapeutics in usage at St. Bartholomew's Hos-

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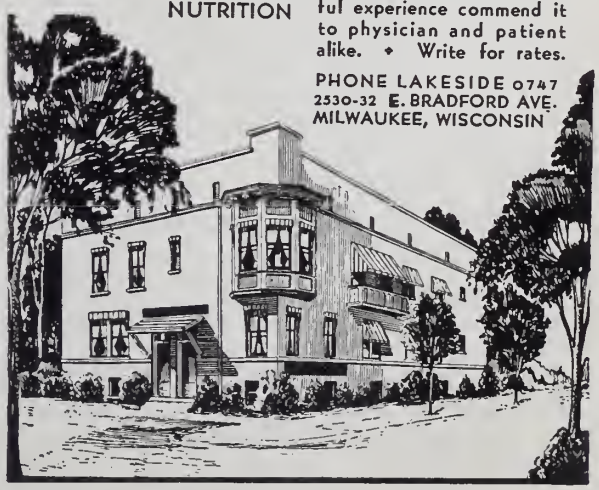

pital. The author begins with a short history of diathermy, which includes individuals and their contributions to the therapeutic field. A good portion of the text is given over to explanations and descriptions of the various types of therapeutic machines, which includes many plans and drawings.

The text may be outlined as containing in a general way:

a. A history of diathermy.

b. The mechanics involved with electrotherapeutic machines.

c. Electrotherapeutics in connection with, 1. Medicine, 2. Surgery.

Regional technic and treatment is discussed.

To the student and layman, this text is invaluable. The description and action of diathermy, together with its application, is compiled and edited in a clear, concise manner. It is a valuable contribution in the field of medicine and surgery in physical therapy. O. E. B.

PRESS SERVICE

(Continued from page 53)

and tuberculosis, chronic invalidism and indirect deaths, the evil record of which can not be recorded.

During the past ten years, pneumonia has been the cause of 23,805 deaths in Wisconsin as follows:

Year	Deaths	Year	Deaths
1921	2,093	1926	2,381
1922	2,463	1927	1,926
1923	2,939	1928	2,571
1924	2,511	1929	2,244
1925	2,525	1930	2,152

"While the disease occurs everywhere in the United States, it is more frequent in the cities, probably as a result of overcrowding, bad ventilation and the more or less definitely established contagious character of predisposing colds," declares the Educational Society of the Wisconsin Medical Society in the warning issued today.

"The term 'pneumonia' is loosely used and includes several diseases differing in their cause and varying considerably in their seriousness. The one constant feature of all is the congestion and solidification of a portion or portions of the lung tissue; the serious results depend on the amount of consolidation, the poisonous character of the germ causing the inflammation and, above all, on the character of the body resistance of the patient.

"For instance, a common type is the one following ordinary colds or bronchitis, and is merely an extension of the inflammation to small areas here and there throughout the lungs. It occurs frequently in children and in elderly persons. If the areas affected are not too numerous and if a child patient is vigorous, the outlook is usually favorable. If, on the other hand, the child is feeble, poorly nourished or the victim of other weakening conditions, the disease is much more serious and may be fatal. Especially does the poor circulation of the aged render this condition serious and too often fatal."

CHRISTMAS GIFTS

Madison, Wis., Dec. 24.—Wisconsin's greatest Christmas gift to its people is good health.

Since health begins in the home, the Educational Committee of the State Medical Society today listed five things which will aid in giving health: (1) Fresh Air; (2) Sunshine; (3) Pure Water; (4) Exercise; (5) Careful Eating.

"Those five things will bring you a Christmas present more valuable than the money spent at this year's yuletide," declares the health bulletin of the State Medical Society of Wisconsin.

"Many people exercise too little. Many more eat too much. If more people took a good walk after Christmas dinner, they would be able to work better the next few days. Health is Wisconsin's most precious Christmas gift.

"The ordinary hot air furnace provides for the admission of fresh air as do the indirect systems of steam and hot water heating; but when radiators are placed in the rooms, heating too often means raising the temperature of the impure and stagnant air, which often remains unchanged for hours, regardless of the number of people who breathe it.

"It may add something to the expense of houses and places of business, to provide for the constant admission of fresh air and the discharge of that wh ch has been made stale. Health, however, depends upon the quality of the air breathed, and the added expense required for heat, plus ventilation, is demanded when health is considered. Heat without ventilation is largely responsible for the colds and the increase in pneumonia during the winter months.

"Sunshine is an even more potent factor. It destroys disease germs, stimulates the system, stirs the sluggish blood and imparts a vigor.

"Typhoid fever rate is usually an index to drinking water, milk and food sanitation conditions. Records show that Wisconsin had in 1910, 2,446 cases and 558 deaths from typhoid fever, while last year, 1930, we had but 195 cases and 25 deaths. Further, we have good reason to believe that these numbers can still be reduced by applying known remedies, such as better protection of private water supplies, control of typhoid carriers, typhoid vaccine, improved medical and hospital service, and finally, cooperation on the part of the general public to the end that typhoid will no longer be a serious health problem."

Racine Clinic Recently Opened

The Racine Clinic building illustrated above was opened on September first, 1931. Organized by Drs. F. C. Christensen and Charles E. Constantine, it is housed in a newly constructed, two-story building at Eighth and Main streets, two blocks from the main business section of Racine. It has offices for six physicians.

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For a good many years we have been engaged in the investment business; but we have yet to discover a "standard" investment program fitted to all individuals.

There is, however, one investment program accurately fitted to *your* needs. It is the investment program planned for you alone, planned with your particular problems, circumstances and responsibilities always uppermost.

This fully explains why it is our unvarying policy to recommend to our clients only those sound securities which most adequately fulfill their particular requirements.

Isn't this individualized investment counsel exactly the kind of investment service you need to simplify the handling of your investment affairs?

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When decalcification occurs during pregnancy

IT IS important to warn expectant mothers of the danger of calcium deficiency during pregnancy. For unless there is sufficient calcium to take care of the developing *foetus*, there will be a *withdrawal of calcium from the maternal structures* —resulting, among other things, in rickets, soft bones, and carious teeth.

During this period Cocomalt is highly valuable for two reasons: It contains Vitamin D which mobilizes calcium, and it is mixed with milk which in itself is an essential source of calcium.

Recommend this delicious chocolate flavor food drink to expectant mothers. Not only does it contain Vitamin D—not only does it add 70% more nourishment to milk—not only is it tempting to finicky appetites—*it supplies extra body-building proteins, carbohydrates and minerals so essential to the mother and to the coming child.*

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The main floor plan consists of a large waiting room, secretary's office, diagnostic and therapeutic x-ray department, physiotherapy rooms, and laboratory. It has four consultation rooms with adjoining treatment rooms.

The first floor also has a waiting room, an emergency room, drug room, library, and offices for a genito-urinary department. It also has living quarters for the caretaker.

STATE HOSPITAL COSTS

(Continued from page 51)

ceive adequate treatment at home or in a hospital, at the same or less expense to the county.'"

* * *

Without expressing an opinion on the question which you ask, I call attention to the specific provisions of ch. 142, Stats., that it seems to me make the question of the judge's determination as to the comparative expense of the county pretty much a matter of simple mathematics. Sec. 142.05 provides that all transportation expense where the patient is unable to provide the same shall be paid by the county. Sec. 142.08 (1) provides that the net cost of caring for a patient at Madison shall be paid one-half by the state and one-half by the county. Sec. 142.04 provides that if the judge find "that the person can receive adequate treatment at home or in a hospital, at the same or less expense to the county, and the person to be treated shall not make the selection aforesaid, he shall enter an order directing such treatment, * * *."

SECOND OPINION

October 20, 1931.

Giles V. Megan,
District Attorney,
Oconto, Wisconsin.

You write that the "county judge has submitted the following questions which I would thank you for answering."

* * *

The questions the county judge asks are:

(1) Is there a restricted class of cases which the county judge can commit to a hospital under chapter 142, and what cases would come under such class?

(2) Is it mandatory on the county judge to order a person sent to the general hospital upon proper application and physician's certificate or can he use his own discretion in each instance?

(3) Also what discretion has the county judge in the matter of choosing between a local hospital and a general hospital?

Without expressing an opinion, I call attention to the express language of the statute as to each of the above questions seriatim, which it seems to me answers them.

(1) Context unquoted here shows that settlement and indigency is not being inquired about. Sec. 142.01:

"A person * * * who is crippled or ailing and whose condition can probably be remedied or advantageously treated."

Sec. 142.03 (3) (b):

"A crippled person for the purpose of this chapter means one who has some physical defect such as affections of the joints, affections of the bones, disturbances of the neuro-muscular mechanism, congenital deformities, static and other acquire deformities, that may be corrected or improved by orthopedic surgery or other special surgical and medical care."

Other sections refer to the "required facts."

(2) Context unquoted here shows the inquiry to be solely as to whether the judge is bound by the application and physician's favorable report. Sec. 142.04:

"If the court shall be satisfied that the required facts exist and that the person should be treated at the 'hospital,' he shall so find and enter an order so directing. * * * If the court is not so satisfied he may make further investigation."

(3) Sec. 142.04:

"If he find the required facts and that the person can receive adequate treatment at home or in a hospital, at the same or less expense to the county, and the person to be treated shall not make the selection aforesaid, he shall enter an order directing such treatment, the place thereof, and the physician or physicians. If the court is not so satisfied, he may make further investigation."

THE DOCTOR SPEAKS

(Continued from page 52)

County Medical Society who, a year or so ago, took time from their busy days for a course in public speaking. And it was some such point of view as this that led your editor to ask me to prepare a series of short articles on speech preparation, setting forth what, in football, they call "the fundamentals" for the busy reader who has no time, at the moment, to go into the matter more thoroughly. And so, let us begin.

TWO GENERAL TYPES OF SPEECHES

(A) Motivative Speeches. Most of our everyday talks are attempts to get our audiences to act in some definite way. The campaign speech aims to secure votes; the class lecture, to get the student to say, "I understand what you mean"; the after-dinner speeches, to produce laughter and applause; the health talk, to advocate reforms in matters of exercise or diet. Such speeches may be written in faultless English and delivered with the most pleasing voice and gesture, but if they do not secure the desired response, they must be regarded as failures. Beauty of sound is not enough; the hearer must react definitely and affirmatively to the speaker's ideas.

(B) Demonstrative Speeches. There is another type of speech that makes an impression of quite another sort. Prominent in this class are the speeches of courtesy; that is, presentation and acceptance speeches, welcome and farewell addresses; eulogies,

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The Mounds Park Sanitarium

In twenty-five years of service, through its staff, its facilities and its cooperation with physicians of the Northwest, Mounds Park Sanitarium, a general hospital, has gained the distinction of conducting one of the leading psychopathic departments of the Northwest.

It is an advantage to treat mental disease in a general hospital because it has complete equipment and a staff of consulting physicians and surgeons, to treat physical conditions which may or may not be responsible for the mental symptoms existing. Treatment in a general hospital likewise removes any possible stigma of having been confined in a psychopathic institution and allows a patient to return more easily to his former social status.

Upon request, of any physician, the Sanitarium will be pleased to send the details of its service and rates.

SAINT PAUL
MINNESOTA

dedicatory addresses, and the like. On such occasions the audience often knows about what the speaker will say before he begins to speak; consequently, attention during the delivery of the speech is focused on the manner of speaking more than on the subject matter of the address.

Speeches of this sort affect the hearers in much the same way as they are affected by hearing songs well sung. As in the song, the meaning of the words is not the most important consideration. One can hear songs many times without paying much attention to the words themselves; instead one reacts to the pleasing succession of sounds, to the tempo and the rhythm; and one's reaction is apt to be a mood. So it is with this type of speech. If such an address plays on the ear drums with a series of pleasing sounds, creating a mood that is appropriate to the occasion, the audience will rightly feel that it has been a success, though they remember little of the meaning of the words.

In these articles we shall deal almost exclusively with the speeches of the first type.

STEP I. EVERY MOTIVATIVE SPEECH SHOULD HAVE A DEFINITE PURPOSE

No speech should be made unless the speaker has a definite purpose in making it. Unless you want to get some definite reaction from your hearers you had much better save the time of the assembly. Determining this purpose is the first step in preparing your address. Until this has been done you are in no position to gather material intelligently or to outline what you are going to say.

Henry Ward Beecher, who became one of America's formost pulpit orators, tells us that he had been attempting to preach for two years before this idea of taking aim at a definite reaction on the part of his hearers occurred to him. It has never occurred to many speakers who have been talking for a much longer time than that. Neglecting to ask oneself, "Just what do I want my hearers to do?" constitutes one of the most frequent reasons for failures in public speaking.

It is evident that any attempt to classify the various purposes for which speeches are made must be somewhat arbitrary. However, if we analyze speeches from the point of view of the complexity of the desired response, we can distinguish four different purposes:

(A) To Divert. There are occasions when one must talk without having a great message to deliver; there are times when all audiences want simply to relax and to be entertained. Life is real and earnest enough without being told about it all the time. The speaker who can successfully entertain others with a series of stories or an account of his unusual experiences is in great demand. Nearly every convention wants on its program after the day's work is done some one who can make the audience laugh—and laugh heartily.

For many, this is the hardest kind of address to do well. The seemingly aimless talk of the entertaining speaker was probably carefully worked out and rehearsed many times beforehand. Beginners would usually do well to start practising on other kinds.

(B) To Arouse Enthusiasm. This kind of speaking aims to arouse the audience to a firmer grip on conventions they already hold. We all tend to grow weary in well doing; sometimes the vision fades and we grow discouraged. It is at such times that speeches of this type are needed. The university homecoming is an occasion for rearousing one's loyalty for his alma mater; the father-and-son banquet brings us again to a realization of how much we think of our sons and how little time we have been able to spend with them; the convention speaker makes us feel again the nobility of the task to which the medical profession is called and the challenge to alleviate human suffering.

Such speeches may tell us little that is new; they do not attempt to get us to accept new ideas. They aim rather to create new loyalty for old beliefs.

(C) To Inform. Here the speaker aims to give his audience information which it does not already possess. Members of the medical profession gather to hear some of their number tell of a new treatment for some disease; at the farmers' institute the speakers tell of the effects of fertilizers, of new and better ways of feeding cattle.

PHYSICIANS' EXCHANGE

Advertisements for this column must be received by the 25th of the month preceding month of issue. A charge is made of $2.00 for the first appearance of copy occupying 1 inch or less of space and $1.00 for each succeeding insertion of the same copy. Kindly accompany copy with remittance to cover number of insertions desired. Advertisements from members of the State Medical Society will be accepted without charge. Such copy will be taken out after its second publication unless otherwise requested. Where numbers follow advertisements replies should be addressed care Wisconsin Medical Journal.

WANTED—Used bedside x-ray, operating table, office examining desk, sterilizer, etc. Must be in A1 condition. Address Number 856 in care of The Journal. ND

FOR SALE—Entire office equipment of the late Dr. Nolan for sale, in whole or in part. Office furniture, surgical instruments, and library. Excellent location for a physician. Write Mrs. W. N. Nolan, Kaukauna, Wis. DJF.

WANTED—Locum Tenens work by experienced physician; available now for short or long period; licensed in Wisconsin; reference furnished; will not compete. Address No. 851 in care of Journal.

WANTED—Partnership or assistantship with general physician and surgeon. Class A training, four years' experience, and a year of P. G. work in Europe. Age 31, married. Address No. 860, in care of The Journal. JFM.

POSITION WANTED—Eye, ear, nose, throat specialist willing to assist in general practice and surgery. Wants association with busy physician and surgeon. Address Number 854 in care of The Journal. ND

WANTED by woman physician, Michigan graduate, position in small clinic. Interested in internal medicine and gynecology. Wisconsin license. References. Address No. 849 in care of the Journal. OND

FOR SALE—Entire office equipment of the late Dr. Fremont E. Chandler, Waupaca, Wis. This includes office furniture, safe, scale, quartz light operating chair, instrument tables and cases, instruments and library. Address Dr. Fremont A. Chandler, 180 N. Michigan Avenue, Chicago, Ill.

MADISON OFFICE space for rent in conjunction with general practitioner, on prominent downtown corner. Attractively and completely furnished. Address No. 852 in care of the Journal. OND

X-RAY TUBES FOR SALE—Fine, medium and broad focus Universal type, 10 and 30 M. A. radiator type Coolidge tubes for sale $50 to $90. Address Westinghouse X-Ray Company, 1417 W. Wells St., Milwaukee, Wis.

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SPLENDID OPPORTUNITY to rent attractive suite of offices in Medical Arts Building, Milwaukee. Adjacent to Milwaukee Academy of Medicine library and meeting rooms. Ideal location for down town physicians. No other doctors in building. Length of lease optional. Address Dr. Eugene A. Smith, Custodian, Medical Arts Bldg., 507 East Wells St., Milwaukee. OND

FOR RENT OR SALE—Residence and office combined; especially built for doctor. Excellent territory in good farming country. Place vacant on account of death of doctor. If interested come and look over personally or write to the owner, Mrs. M. P. Cady, Birnamwood, Wisconsin. DJF

FOR SALE—Established practice of the late Dr. Dreyer at Wheeler, near Menomonie, Chippewa Falls and Eau Claire, and seventy miles from Twin Cities. Also large modern home with steam heat and oil burner. Will rent or sell, both very reasonable. Address Mrs. Celia Dreyer, Wheeler, Wisconsin. DJF

WANTED—Physician with seventeen years' practice and six months' postgraduate work in Europe in internal medicine wishes to become associated with physician doing internal medicine or surgery in Milwaukee. Willing to purchase or install new office equipment such as electrocardiograph, etc. Address No. 859 in care of the Journal. JFM.

PHYSICIAN WANTED—Leaving good location in south central Wisconsin. Want good physician to take over my practice. Very small investment. No initial cash payment necessary. Write Number 858 in care of the Journal. NDJ

WANTED—Dentist, competent, to locate in eye, ear, nose, and throat clinic. Splendid opportunity to build up a paying practice. Write T. W. Ashley, M. D., Kenosha, Wis. DJF.

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Giving information is, or should be, the aim of many of the public health talks. Why is it that such speeches, containing information that should be of vital interest to everyone, are often called dry and uninteresting? One reason is that new material is hard to assimilate. New words, facts, statistics, opinions of experts, theories are not easy to listen to. Another reason is that the speaker talks as though his audience knew as much about the subject as he and expects them to learn in a few minutes information and ideas that it took him years to acquire.

(D) To Convince or to Secure Action. The speech that aims to inform is not concerned with what view you take of the matter. The speaker has gained his end when you say, "I understand." But the type of speech we are discussing does not stop here; if it is successful, the listener must not only say, "I understand," but, "I understand and I agree with you." The occasions for such speeches are numerous. When you argue a moot point in your professional meetings or urge your listeners to have periodic medical examinations you are making this type of speech.

STEP II. DIAGNOSING YOUR AUDIENCE

Having decided your purpose in making the speech, the next step is to analyze the audience before which it is to be given. Until you have studied your patient you are not ready to outline a course of treatment; until you have studied your audience you are not ready to begin building a speech that will fit that definite situation.

It is evident that audiences may be classified in a great many different ways; i. e., on the basis of age, political beliefs, or religious creeds, amount of education, loyalty to a common ideal.

There are, however, two types of classifications that apply to all sorts of audiences on all sorts of occasions.

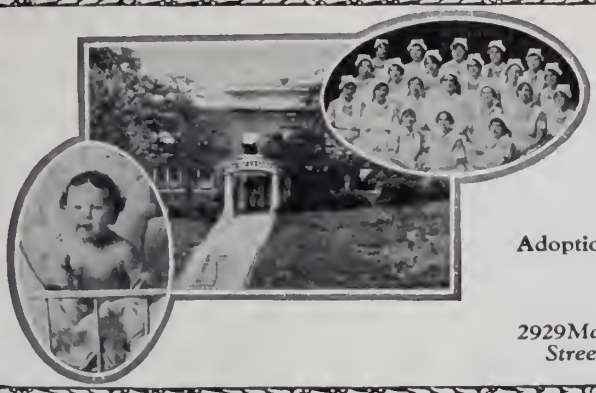
(A) How Much Does the Audience Know About Your Subject? Suppose that you are a specialist and that in your studies you have made a discovery of value. You are asked to make three speeches about it: one before a group of public school teachers; another before a meeting of the State Medical Association; the third, before a small group of colleagues, research workers in your field. Here it is evident that you have audiences with varying amounts of the basic knowledge necessary to a full comprehension of the importance of your discovery. These three audiences would properly require three different speeches.

The group of public school teachers would have little or no technical knowledge of the subject. In this speech you would have to take great care to avoid assuming knowledge that they do not have. Those long, seven-dollar terms that have to be folded twice to go into a suitcase cannot be used here, valuable though they may be in conveying precise meanings to colleagues. A great part of this speech should consist of explanations and illustrations that come within the experiences of your hearers; when, occasionally, a technical term creeps in, it must be explained and defined in words that laymen can understand.

A speech of this sort must not cover too much territory. There is a decided limit to the amount of information that a beginner in a field can assimilate at one time. Your memories of your early days in the medical school provide ample evidence of the accuracy of this observation. Remember, too, that the lay audience is usually only mildly interested and does not have the incentive to listen that members of your profession have. The early part of such speeches should be devoted to arousing the interest of the listener in your subject by showing how it affects him.

As I write I have before me a copy of a radio address on Cancer by Howard W. Haggard, M. D., Associate Professor of Physiology at Yale University. I quote the following from a section entitled *Chronic Irritation Excites Cancer:*

"Cancer in most instances arises at a point subject to some kind of chronic irritation and inflammation. The irritation is believed to be the exciting factor in stirring up the cells to ungoverned growth. One of the first observations of this kind was made on the members of a native tribe in India.



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Many of the men and women were subject to cancer which started in a most unusual place—the skin on the surface of the abdomen. Further investigation showed that these people had a custom of warming themselves by strapping to their bodies little metal boxes filled with burning charcoal. The continual slight burning caused a chronic inflammation. Prolonged irritation finally started cancerous growth.

"You would hardly expect to find a similar custom among the people of our country, but nevertheless there is one analogous to it, one which in the past, at least, has been responsible for many cases of cancer. You have seen old men who smoke short-stemmed clay pipes . . ."

I happened to tune in as the speaker was speaking these paragraphs and I listened through to the end of the twelve-minute address.

At the other extreme would be the audience of fellow research workers. They would be impatient if you took time for definitions and non-technical illustrations; for them it would be a waste of time. Instead of non-technical language you would take great care to use technical terms that express your exact meanings and your illustrations would be in the nature of cases cited. This speech can cover much more territory than the one intended for the popular audience. The hearers have a great store of experiences that they can call upon to give meaning to the abstract terms. They are already interested and their attention will not lag so quickly. A good speech for the lay audience would be much too elementary for this group of experts; a good speech for the experts would be too heavy for the lay audience.

Somewhere between these two extremes would be the third group, the members present at the state medical meeting. The doctors would have much more knowledge of the subject than the school teachers, but they would not all be familiar with the specialized techniques and the vocabulary of the research worker. The speech for this group should be a compromise between the two we have already discussed.

(B) What is the Attitude of the Audience Toward Your Proposition? Here again, we can make a three-fold classification:

(1) The audience that is already favorable.
(2) The audience that is in doubt.
(3) The audience that is against you.

We should note, at this point, that the first reaction of the average audience to any new proposition is one of indifference or hostility. This is especially true if the speaker is attacking cherished beliefs or something that the hearers regard as fundamental to their way of living. It required years of effort and tens of thousands of speeches to convince even a majority of our citizens that negro slavery should be abolished. Almost as much time and agitation were necessary to combat the deeply grounded prejudice against woman's entry into the professions.

Not even the best speech in the world could successfully overthrow these deepest prejudices at the first attempt. If you are attacking something that your hearers have come to regard as a necessary evil, they will at first pay little attention to you; if you persist, they will be irritated; if you still persist and your position is sound, they will begin to say, "Well, maybe there's something in it . . ." Public opinion, like Rome, was not built in a day.

The audience that is already favorable is ready for the speech that aims to arouse enthusiasm. These listeners do not want a careful analysis of the evidence; they want rather an enthusiastic assurance that the beliefs they hold are right. "Listen to sermons, pep-talks, political speeches, trade and business talks, and notice that a good half or more of their content is made up of stuff that everybody knows but delights to hear said out in meeting."

The audience that is in doubt contains the people who are open minded on the subject. They want more facts before they give their endorsements; they are best pleased by a well-reasoned speech that begins at the beginning and, carefully supported by proof, proceeds logically to the conclusion.

The audience that opposes you calls for the greatest tact. It does no good to make

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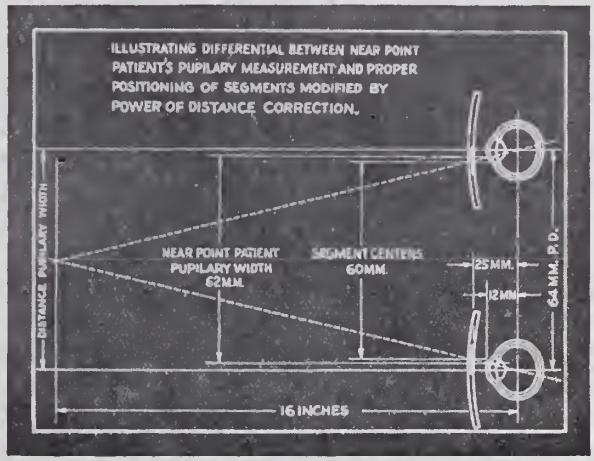

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a direct attack on their beliefs. I quote a recent textbook on public speaking by Woolbert and Weaver; "avoid the direct collision by somehow disarming your opponents. The one best way to do this is by quoting somebody the audience admires. Next best is to make the audience like you personally. Get them to do this and they will believe what you say if you seem sane and honest. After that you can safely argue a little . . ."

In the speech to the hostile audience always begin with points of agreement, going carefully from the known and accepted to the unknown. Avoid anything that will make your hearers say "No" at the start; having said that they will feel bound to stand by it. If possible, cite authorities that have once been with the audience but have changed to your position on the basis of new evidence.

Now, having decided the purpose of our speech and having studied the audience before whom it is to be given, we are ready to consider the process of speech building. How shall we begin? How organize the body of the address? What style is best? And how shall we conclude? These questions form the basis of the next article which will appear in the next issue.

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In addition to the articles previously enumerated the following have been accepted by the Council on Pharmacy and Chemistry of the American Medical Association.

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MENTAL HYGIENE

Lloyd H. Ziegler, Albany, N. Y. (*Journal A. M. A.*, Oct. 17, 1931), reviews briefly the history of the mental hygiene movement in the United States and presents the results of interviews among 103 physicians practicing medicine and surgery relative to their interest and problems in neuropsychiatry. He believes that there is need and desire for more knowledge of mental hygiene among these practicing physicians and that mental hygiene is part of a public health movement, depending on knowledge and education in which the medical profession of the future will be required to take a larger responsibility.

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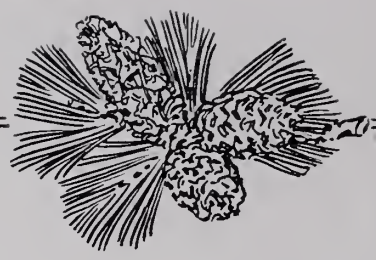

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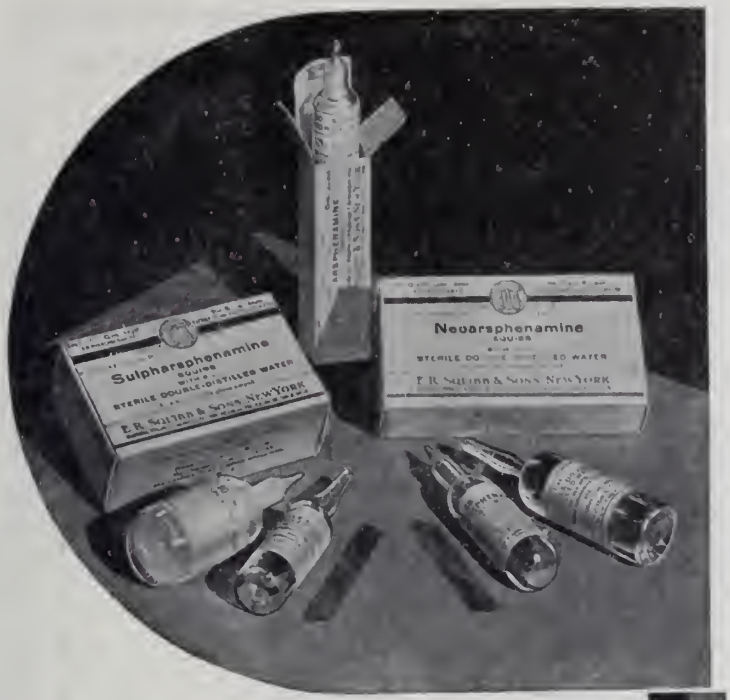

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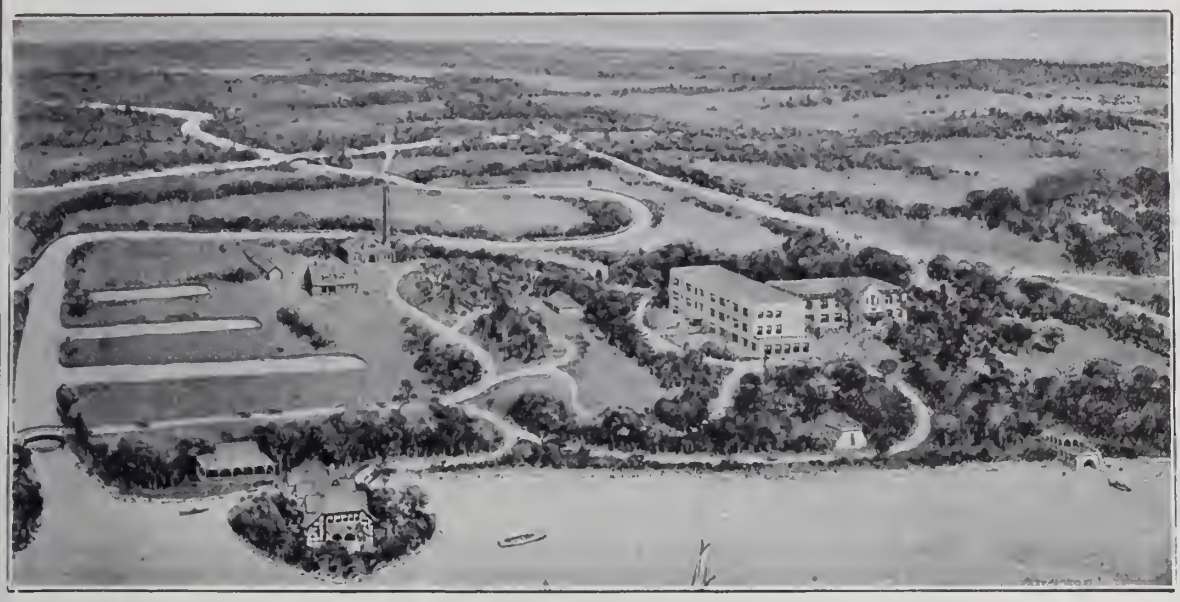

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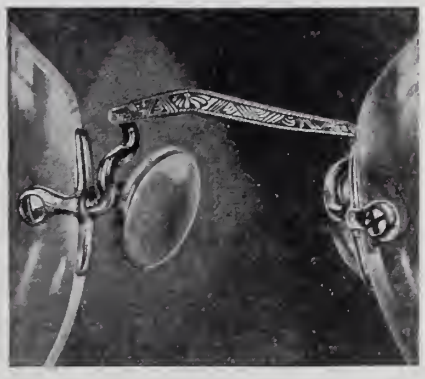

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The Wisconsin Medical Journal

Volume XXXI FEBRUARY, 1932 No. 2

Idealism In Medicine*

By JOHN M. DODD, Sr., M. D.
Ashland

The ideals of the medical profession have made it the highest privileged class of people in the world; for, what can be a higher privilege than to have human life placed in one's hands and except in gross error or failure to be accountable to none except his own conscience?

In its efforts to keep these ideals as the guiding spirit in the healing art, Hippocrates the "father of medicine" formulated the oath, which bears his name, and with which, until recent years, every graduate in medicine was required to familiarize himself. The American Medical Association, in order to make the principles promulgated in that oath applicable to the needs of modern civilization, has adopted a code of ethics defining the relations of physicians to patients and to one another. These rules of conduct are intended to sustain and perpetuate the high place which the practice of medicine has attained through the centuries as an agency to prevent suffering, to prolong life and to promote happiness. In this materialistic age when all human pursuits are being weighed in the balance and evaluated as to their general usefulness to the world, the practice of medicine, and this includes surgery and the specialties, must naturally come in for its share of public analysis. Its aims, its objects and its results are subject to rigid scrutiny and the means to its ends will in large measure, in the near future, determine the place it is to occupy in the public esteem and confidence.

The profession itself, through medical laws and boards of examiners, endeavors to determine the qualifications of applicants for admission to the practice of medicine but makes no effort to ascertain the quality of idealism which actuates the desire to be admitted to medical practice and has but limited control over his conduct after he is once admitted. Whatever it may be that attracts men to the medical profession, the urge comes from one of three primary sources: The desire for a lucrative profession with the social standing it affords; a love of science, or the spirit of service and desire for a useful life. These reasons doubtless come in the order named; shifting, possibly uniting and crossing each other in varying degrees as experience with the complex problems of life come to him.

The first concerns itself with the material needs of man, the second treats the human being as an agency for the manifestation of natural laws and the third is an expression of desire to function for the benefit of the race knowing that thereby he will in some way receive ample reward.

One cannot accept the responsibilities for the preservation of health, happiness and usefulness without feeling that there rests upon him an obligation to give the best there is in him in the service of his fellows, minimizing his own personal interests, pecuniary or otherwise. Most men are idealists when confronted by a fellow being in distress, yet, there is ever a warfare between the ideal and the mercenary—self interest with the welfare of those entrusted to our care. To discuss the possibility of exploiting patients for personal gain would lead us far afield and would be beyond the intent and limits of this paper.

We have had handed down to us through a long ancestral lineage the spirit of service above self and it is this spirit that keeps the medical profession in the forefront of those agencies which promote human happiness. I need not attempt to recount to a group of medical men the many problems presented

* Presented before 90th Anniversary Meeting, State Medical Society of Wisconsin, Madison, Sept. 1931.

to us in the matter of social relations, health and moral welfare, or the attitude of doctors of medicine toward each other, for each one of us who has practiced for a quarter of a century or more could fill a good sized volume with such experiences of wide range and variety.

The conscientious physician is cheered by the thought of the lives he has saved, depressed by the mistakes he has made—known only to God and himself and urged by something within him to do his best when opportunity comes to use the knowledge and skill he has acquired. He is happy when gratitude expresses appreciation of his successful efforts, and he learns to accept ingratitude with philosophic resignation when he knows the opposite has been earned.

How often, as he meets the grave situations devolving upon a practitioner of the healing art, does he exclaim in the distress of soul as Cain of old, yet from different cause "Am I my brother's keeper?" How often must he decide by himself the problem —am I doing all that should be done for this patient? If "uneasy lies the head that wears a crown" how about the physician or surgeon who realizes that a human life lies within his hands and the issue will depend on his doing the right thing at the right time. Then if his head does not direct and his hand execute the proper procedure a tragedy may result. In the complex problems of human relationships the physician must be a judge and weigh the evidence that comes to him from sources that must be held confidential and sacred without the publicity of trial in open court and with no counsel except his own conscience. There is deeply rooted in the hearts of men that principle of conduct accredited to the Christian era but undoubtedly extending much further back into antiquity—do to thy fellow man as you would have him do to you were your positions reversed. This is the foundation of all ethics and is so simple that elaborate codes, pledges, etc., would seem to be superfluous.

Men in their complex relationships incident to modern life have prescribed certain rules governing the application of this principle as in the Code of Ethics of the American Medical Association and the fellowship pledge of the American College of Surgeons; actuated by the highest motives, no doubt, but woefully ineffective in keeping men within the concept of the Golden Rule.

There are too many indications that men regard laws and rules of conduct as made for the other fellow and obligations are taken with crossed fingers. Too little attention is given to ethical teaching in our medical schools. The mind is crowded with scientific data without much time being given to the application of this data in the treatment of the complicated problems of health and disease or in considering their effects upon that mysterious agency — the human mind and the equally complex organization, the human body.

Without an ethical background in his medical training the young doctor is badly handicapped in applying his knowledge in the treatment of his patients and in his professional relationship with his fellow practitioners. An old doctor when asked what is the most important subject in the study of medicine replied, "human nature", and it must be admitted that there is abundant food for contemplation in that rather terse reply.

If all doctors were idealists there would be no difficulty in applying these ideals in practice nor would there be danger of the profession degenerating into a commercial trade. When doctors reveal the inner workings of their minds, we find in most of them a foundation of idealism, but many of them have by their associations and environment gradually submerged the ideal in the practical and have accepted in greater or less degree that travesty of the Golden Rule: "Do to the other fellow as he does to you but do it first." What a dismal world this would be if this spirit actuated all men.

A TEST OF CHARACTER

There is no greater test of character than that laid upon the man who is given a diploma and authority to practice medicine. The results of this test are demonstrated by the way he has used his talents and his privileges. The ideals of the medical profession find expression in the language of the poet: "Then give to the world the best you have and the best will come back to you." The

physician will question this as he grows older. Will the best come back and if so in what form will it come and will he recognize it when it does come? Does one ever look back with the feeling that the bread he has cast upon the waters has returned? Does he ever question—"Every good deed nobly done will repay the cost." What are the compensations and rewards for a life well spent in the service of humanity such as is given by the physician? They are not in the accumulation of this world's good for no one can become financially rich in the legitimate practice of medicine. They are not in the gratitude of those he has benefited for this will fade as he grows old and younger men are called to take his place. They are not in the fellowship of his contemporaries for he may see every principle of the ethical code outraged and condoned by the rest of the profession. If he is so fortunate as to retire at the height of his usefulness he may retain the satisfaction incident on a useful and well spent life without the heartaches of receding friendships that come with age. He may have the satisfaction of knowing he has not only performed his part in active life but has passed on to those who are to follow after him those things which will better enable them to do their part.

Medical ideals are sadly neglected in the curriculum of the modern medical college and are taught only in the lives and conduct of the teachers and the fellow practitioners with whom the novitiate comes in contact in practice. Idealism in its true sense is the dividing line between the gentleman and the boor. By following its dictates, and everyone who can graduate in medicine should be capable of acquiring if he does not possess this idealism, we can hope to retain that place in the confidence and esteem of the world which has given us an honored place in the affairs of men.

Lodges and fraternities have done great good in their teachings of the relations of men to one another and of their obligations to society. The principles of true gentility underlie all ethics and form the foundation of our ideals. If all doctors were gentlemen in the true sense of the word there would be no need for codes of ethics. Unfortunately some can be guided only by the printed rule and even then some are unable to properly interpret the rule or ignore it altogether. If we allow selfishness or commercialism to submerge these ideals we may look for social medicine or some plan that will make of our profession a servile caste which will lead to degeneration and throw to the winds the glorious achievements of medical science during the centuries past. Already there are indications of desire on the part of the public to direct our activities. Our apparent indifference to the signs of the times will soon bring us regrets. Many agencies are at work taking from the doctor the direction of matters pertaining to public health. We cannot remain indifferent if we expect to hold our place and retain the direction of affairs which are the concern of competent medical men.

Medicine is not an exact science except in a few particulars, and the human organism is so variable in its reaction to the influence of stimuli acting upon it that no set rules can define the limits of health and disease nor can physiological processes be controlled at will, except with a few drugs, vaccines or glandular extracts.

Medical education should have a good foundation in scientific fact and logical deduction with due regard to the forces of nature and the influence of mind over matter based on the recorded experience and observation of the pioneers in medical progress. Science alone cannot keep us in the vanguard of the agencies for the prevention and cure of disease.

There must be an altruistic spirit of appreciation of the mission of the doctor and a deep-seated desire to be of service to his fellows and to add his mite to the sum of human happiness during the brief period of his sojourn among the living forces of the world.

The greatest service one can render to mankind is to endeavor to reach the highest possible level and then with a helping hand lift his fellows toward it. Human progress cannot come from man's establishing a low plane and then pulling his fellows down to it, and then we say:

"Do what thy manhood bids thee do,
From none but self expect applause;
He noblest lives and noblest dies
Who makes and keeps his self made laws."

The physician is an individualist; his relationship with his clientele makes him so, but one mind cannot encompass the whole field of medicine. Fortunate indeed is he whose idealism prompts him to surround himself with facilities and professional associates so as to give to those who come to him the best that science and skill afford, and yet he finds many disappointments awaiting him in his associations.

Group practice has come to stay and health centers with social service and group nursing under competent medical direction are coming. There are indications that some form of health insurance may come in solution of the problem of providing the poor with competent treatment and hospital care. The profession realizes that it has to carry more than its share of the burden of caring for the indigent sick and for those who cannot or will not pay. No doctor possessing the true idealism of medicine will refuse his services to the poor, and the public is quite content that he should do so. Emergency cases cannot wait for the machinery of poor relief, as it exists in the usual town and county, to function. Petty politics obstruct the efforts of the doctor and hospital to obtain compensation for service that has been rendered. To be sure, the state has made some provision in legislation but its processes are often too slow to meet the situation. There is an evident lack of centralization of health agencies in our state and the control of them is gradually slipping from the hands of the medical profession. Unless we wake up and assert ourselves, the public will do for us the things we should do for ourselves. Commercialism is evident on every hand in our own ranks. The College of Surgeons has not abolished fee splitting any more than the 18th amendment has abolished the liquor traffic. In both instances our idealism has failed.

I am aware that this paper has dealt with the diagnosis of the situation but has only hinted at some of the remedies to be applied. A consultation is needed and a remedy found. The idealism of an honored profession points the way. How shall we make it practical?

Positive Factors in the Diagnosis of Pulmonary Tuberculosis

By H. M. COON, M. D.
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Perhaps an explanation is called for in presenting the subject of the diagnosis of pulmonary tuberculosis in the face of present day statistics regarding the declining death-rate of this disease. However, institutions caring for this class of patients are still admitting the greater proportion of patients in the advanced stages, that is, either moderately or far advanced; the admissions in these two classifications combined amounting to from 75 to 90 percent of all admissions. When these admissions are further divided according to age groups, the groups from 15 to 35 years still lead all other groups, but within the last five years there has been a decided shift in that the 15 to 20 year group is increasing, with a consequent decrease in the upper age group. The economic disadvantage of advanced tuberculosis in young adults is of course apparent. What effect present economic conditions will have on the incidence of tuberculosis in young adults is but a matter of conjecture at present, if the recent past is to be our guide, it may well be a matter of grave conjecture. And for that reason the discovery of the earlier pulmonary manifestations would seem well worth while.

Because pulmonary tuberculosis is chiefly a chronic disease, and slow in its development, it would seem that it should be relatively easy to discover in its earlier stages, but the very fact that its development is slow, makes it difficult. After a positive diagnosis has once been established, in going back over the history, it is often possible to pick out incidents that might have been better guide posts than they were. In other words, in pulmonary tuberculosis, as in no

other condition, it is true, that "hindsight is better than foresight."

The diagnosis of advanced tuberculosis is comparatively easy, and this sequence of events is not at all uncommon: a patient presents himself with the history of cough and expectoration present for several weeks; a sputum specimen is examined and found to be positive. Then a physical examination reveals enough in the way of signs to call for an x-ray examination, the films showing considerable amount of hitherto unsuspected involvement. And the diagnosis of advanced tuberculosis is made. But what of the year or two or even three that have elapsed in progressing to this stage? Were there no warning signs or "accidents" that would have made the diagnosis possible at an earlier stage? There are at least two factors, and possibly a third, that are of great significance, yet are often overlooked, or at least not properly evaluated.

Of diagnostic criteria, the factors that Lawrason Brown lists, are the most useful, and most used. He lists them thus, their importance he designates by their position in the list:

1. Tubercle bacillus in the sputum.
2. Physical signs above the second rib anteriorly and the 3rd spine posteriorly.
3. A parenchymatous x-ray lesion above the 2nd rib anteriorly or 3rd spine posteriorly.
4. Hemoptysis.
5. Idiopathic pleurisy.

So far as the first factor is concerned, there is no question as to its value, but it is more often than not effective in discovering advanced lesions, although it can, of course, be demonstrated at times in the earlier cases. A single negative sputum examination is of very little value, but very often it is much more comforting to a patient to look no further. It should be far more comforting, to both physician and patient, to have a positive diagnosis before the sputum becomes positive. Particularly is this so when it is realized that a positive sputum means cavitation, even though the cavity is too small to recognize by physical examination, and often too small for the x-ray to detect.

Physical signs, in early tuberculosis, are more often than not absent. Percussion note and breath sound changes can be easily overlooked, and rales are not readily elicited, as a result more and more weight is being put on the x-ray findings. Time does not permit a discussion of the relative merits of physical examination and x-ray studies.

The two remaining factors, hemoptysis and idiopathic pleurisy, are "accidents" that might well be emphasized, as they play a much more significant role in the early discovery of tuberculosis coming as they often do as the first manifestation of an active process, even though their significance is so often overlooked. With that thought in mind, five hundred sanatorium admission histories were studied and these figures result:

Hemoptysis had occurred in 92 or 18%,

Pleurisy, dry, had occurred in 81 or 16%, and

Pleurisy with effusion had occurred in 39 or 8%.

In addition, hemoptysis was the chief complaint upon admission in 61 or 12%; pleurisy was the chief complaint in 30 or 6%; and pleurisy with effusion was the cause for admission of 54 or 11%. We have then two factors of no uncertain importance, hemoptysis playing a role in the histories of 30% of these cases and pleurisy being a factor in 40% of this series.

One other pertinent finding, in 41% of all admissions it was possible to get a definite history of the presence of tuberculosis in some other member of the family, and there was usually the story of contact with that member during childhood or early adolescence.

PLEURISY

Pleurisy, and pleural effusion, have long been associated with tuberculosis, but a significant change in our attitude toward pleurisy has been the dropping, during recent years, of the qualifying word, "idiopathic." The text-books list as causes of pleurisy, tuberculosis, pneumonia, cardiac disease, trauma, and so on, ending with "idiopathic pleurisy." The present understanding is that when pleurisy occurs, except in the course of well-defined pulmonary disease, heart dis-

ease, or as the result of trauma, it is necessary to rule out tuberculosis as the cause. True, there are definite conditions other than tuberculosis that will set up pleurisy or pleural effusion, the more common of which are rheumatic fever, pulmonary or mediastinal malignancy, either primary or secondary, sub-diaphragmatic abscess and pericarditis. The majority of cases, however, are of tuberculous origin, from 70 to 90% are the figures usually quoted, with the higher figure more nearly correct.

While not attempting to go into any detailed pathological discussion, a word as to the common sequence of events in the development of pleurisy is justified. William Snow Miller has worked out for us the lymphatic system of the lungs and pleura, and has described the sub-pleural plexus as well as the channels and valves by which infection reaches the sub-pleural region. When the infection is extensive enough, there follows a breaking down of the gland or glands in this area with the discharge of the glandular debris into the pleural cavity. The pleural membrane, being a serous membrane, has a natural reaction to the irritation set up by this foreign material, and an effusion results. The lesion responsible for the fluid is usually in the upper portions of the lung, but the fluid collects at the base, and so attention is directed to the lower chest and the source of the trouble may be overlooked. Two things are accomplished by the production and collection of the fluid, the inflamed visceral and parietal membranes are separated, and the weight of the fluid immobilizes the diaphragm, thereby decreasing the motion of the lung. Should this effusion be withdrawn entirely, we have a return to the original factors of irritation that produced the effusion, and once more the cavity is forced to protect itself in the way it knows is effective. If, on the other hand, only sufficient fluid is withdrawn to aid in the making of a satisfactory diagnosis, the remainder will be absorbed gradually. Under these circumstances, healing of the sub-pleural focus is aided by the mechanical rest afforded to the lung.

Films, taken at the height of the effusion, are of little value showing as they do only fluid and a degree of lung compression dependent on the amount of fluid present, and the underlying pulmonary or pleural lesion is not visualized at all. When films are taken after the complete withdrawal of the effusion, unless there is considerable in the way of underlying pulmonary changes, they, too, are of very little value. It is necessary to allow a period of six or eight weeks to elapse before a reaction sufficient to be demonstrated by films will have occurred. For this reason many cases of pleurisy that come as the first warning of underlying trouble are overlooked.

Ushered in with acute symptoms, fever, pain, and then an effusion, the fluid is withdrawn; no physical signs are elicited; x-ray check-up is of no help; the patient's fever subsides. Often he is allowed to return to his normal life and occupation, but is greatly surprised, two or three years later, to have this earlier pleurisy linked up with the more advanced tuberculous condition that has developed.

Another advantage, debatable though it may be, might also be mentioned. The slow absorption of the effusion means the taking up, in small quantities, of fluid that contains, as guinea pig inoculation often shows, active tubercle bacilli, thereby producing to some extent the action Koch tried to make effective by his tuberculin treatment.

The present practice in treating pleural effusion is, unless the fluid be extensive enough to seriously embarass either respiration or circulation, to allow absorption to take place gradually, and to treat the condition as primarily tuberculous. It is, of course, needless to mention a further reason for leaving the fluid alone, namely, that with repeated needling of the chest, empyema is likely to develop.

HEMOPTYSIS

That hemoptysis, as a factor in the diagnosis of pulmonary tuberculosis, is better understood than is pleurisy no doubt depends on the fact that the spitting of blood is always terrifying to a patient, and so medical advice is quickly sought. Pulmonary hemmorrhage is ordinarily associated with advanced tuberculosis, however, and for that

reason its significance is at times not properly valued. That it may also be the first sign of manifest tuberculosis is often true. At times it would seem to be only a matter of chance which of these two accidents occurs. This may be explained by the method in which the sub-pleural focus happens to break down. When it is through the pleural membrane, pleurisy may result; when it is in the lung parenchyma, hemorrhage may result. In both instances it is often true that with the subsidence of the acute symptoms, physical examination, in the very early case particularly, is of little help, and x-ray examination of no more value because proper time is not allowed to elapse for the reaction to the accident to take place. The x-ray, however, and some times physical examination, is of help when in the course of six or eight weeks organization has begun and can be detected.

Treating cases of hemorrhage that are of questionable origin, as primarily tuberculous, and looking for the focus later is always a more rational procedure than taking advantage of the false security that is offered by the lack of confirmatory physical or x-ray findings at the time of the hemorrhage.

Other causes of hemoptysis as noted in the cases of this series in which hemorrhage was the chief cause of admission were as follows:

Carcinoma	3
Bronchiectasis	1
Pulmonary Abscess	2
Mitral Disease	1

One other cause of blood streaked sputum is worthy of mention, parenthetically at least, pre-menstrual congestion. It is associated with a feeling of constriction in the chest and a slight febrile rise, all of which clears up readily enough with the institution of the menstrual flow. This same occurrence is, however, frequently noted in women with definite tuberculosis, and here too repeated x-ray and physical examinations are necessary to satisfactorily answer the question of the source of the bleeding.

CONCLUSION

In conclusion, five hundred sanatorium admission histories have been studied and the importance of two factors, namely, pleurisy and hemoptysis, in the development of manifest pulmonary tuberculosis has been pointed out. These two conditions should be treated as primarily of tuberculous origin, until tuberculosis as a causative factor has been ruled out.

DISCUSSION

Dr. T. L. Harrington (Milwaukee): There are two or three things in connection with this paper which I would like to emphasize. Pleurisy with effusion, unless following trauma or pneumonia, is almost always tuberculous in origin. I think we can safely say that ninety-nine per cent of the cases of pleurisy, with effusion, in which there is no trauma, are tuberculous.

As Dr. Coon has mentioned, the best treatment for that condition is rest, letting the effusion alone. Sometimes the withdrawal of a small amount of fluid for the inoculation of a guinea pig is warranted, but even though the result of the inoculation of the guinea pig is negative, we still should not say that the pleurisy is non-tuberculous.

For five years after a case of pleurisy, with effusion, the patient should be under the close supervision of his physician, because in a large number of these cases manifest pulmonary tuberculosis develops within a period of five years.

Dry pleurisy in the majority of cases is non-tuberculous. These cases, too, require observation.

Dr. Coon spoke of the sputum examination. Unfortunately, we still have a number of practitioners who, when they get a negative report on a sputum examination, say to the patient: "This is negative, therefore you do not have tuberculosis." One, two, three, or a dozen or fifteen negative sputums do not prove that the case is not tuberculous, and we should be very cautious, indeed, in saying to a patient who has some symptoms of tuberculosis that, because the sputum is negative, the case is non-tuberculous.

Dr. Coon did not mention, and I would like to do so, the value of the tuberculin test. There is a general opinion among a considerable portion of the medical profession that the tuberculin test is of value only in children. I think I can safely say if every adult in Wisconsin was carefully tuberculin tested with a Mantoux test, forty per cent of our adult population would be found negative. If this is true, the tuberculin test has value in adults, and we should use it. There is another thing about the tuberculin test which all of us have not recognized, and that is, the intradermal test in the patient with early active tuberculosis is likely to give a strong positive reaction. That positive reaction, of itself, should set the physician to thinking.

Dr. Coon has said that the trouble with the fight against tuberculosis is the fact that the average patient comes into the sanatorium either moderately advanced or far advanced. Less than fifteen per

cent come in as early or minimal cases, whereas in the neighborhood of forty per cent come in as moderately advanced, and the balance far advanced.

If the fight against tuberculosis is going to be as successful as it should be, the family physician and the general practitioner must learn to make a careful, systematic diagnosis, and to use in that diagnosis every means at his command to come to a conclusion before he tells the patient that he does not have tuberculosis. I thank you. (Applause.)

The Treatment of Pulmonary Hemorrhage

By ANDREW L. BANYAI, M. D.
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Pulmonary hemorrhage is a frequent and dramatic complication of pulmonary tuberculosis, occurring in 25% to 80% of reported series of cases. Hemorrhage may occur from any portion of the pulmonary circulation. Erosion of a blood vessel, aneurysm in blood vessels traversing a cavity or marked inflammatory changes in the adjacent tissues, may be the underlying cause. The degree of pulmonary involvement or the prognosis cannot be gauged by hemorrhage itself, although frequent hemorrhages indicate a progressive process. In this paper only pulmonary hemorrhage caused by tuberculosis will be considered. Careful differentiation from bleeding, arising from other causes, must be made, of course, in every case, although available statistics indicate that tuberculosis is the most common etiology.

The problem of treatment in each case must be determined as the indications call for, and the following have been the most efficacious in our experience.

1. PHYSICAL REST

Bed rest is of primary importance in the early stages of management. This reduces the physical demands placed upon the individual, reduces metabolic activities, and consequently the frequency and extent of respiratory activity in the lungs. It is preferable to keep the patient in a semi-recumbent position because it simplifies the feeding problem and enables the patient to expectorate blood and secretions accumulating in the bronchial tree. Likewise, respiratory excursions are reduced in this position. The patient should be kept in bed during hemorrhage and as long thereafter as there is expectoration of blood, blood clots or streaked sputum. Other factors must be considered as in all cases of tuberculosis.

2. MENTAL REST

Hemorrhage is interpreted by most tuberculous patients as a grave complication and leads to a disturbed mental state. This can be combated by discussion with the patient, and such reassurance is often of more value than any amount of sedatives.

3. INHALATION OF AMYL NITRITE

Efforts to reduce the systemic blood pressure are often of value. Inhalation of amyl nitrite or the use of the more stable nitrite compounds, is often of value. Such agents should not be used if the patient is in shock or the condition of the heart is not satisfactory.

4. COLD APPLICATION TO THE PRECORDIUM

Local application of an ice bag produces reflex depression of the heart action, stimulates a reflex contraction of the pulmonary vessels and tends to keep the patient's activities reduced. Ice chips are usually welcomed, and in addition to their soothing action, help to reduce fluid intake.

5. MANAGEMENT OF COUGH

The routine use of morphine in cases of pulmonary hemorrhage is not always justified, although such medication quiets the individual and tends to suppress the cough reflex. In many cases the patient can be made quiet by reassurance and the use of milder types of sedatives. Efforts to suppress coughing originate in the fear that the patient may die from loss of blood. Such danger is remote and at times is a minor consideration in comparison with the danger of flooding the pulmonary system with extravasated blood. Such material predisposes to massive atelectasis and the spread of the tuberculous process. Bronchopneumonias following hemorrhage would be rare with a

more judicious use of morphine. A word of caution is, therefore, indicated regarding the depression of the cough reflex without consideration of these other factors. Codein is by far a better choice in the management of these cases. Sometimes the cough may be alleviated by mentholated lozenges or swallowing ice chips.

6. COAGULANTS

Coagulants at times are of more value than the extent of their use would indicate. At Muirdale, fibrogen is used routinely and it is our experience that it increases coagulability for a period of eight to ten hours. This material can be given both subcutaneously and by mouth, but should never be used intravenously because of the danger of intravascular clotting. It is also advisable to avoid blood transfusion or the use of antitoxins and sera while fibrogen is being given.

The value of calcium is well recognized in hemorrhagic conditions. This can be given orally in the form of calcium chloride or lactate in daily doses of 45 to 60 grains. At Muirdale, intravenous administration has been preferred. Usually 10 cc. of a 10% solution of calcium chloride or calcium gluconate is given intravenously every four to six hours. The simultaneous ingestion of 5 to 15 grams of sodium chloride seems to have a beneficial action. If the oral administration of the latter disturbs the intestinal tract, 10 cc. of a 5% solution can be given intravenously.

7. TYING OF EXTREMITIES

The beneficial results from passive congestion in the extremities is not as widely recognized as it should be. Such retardation of the circulation increases the coagulability of the blood in the extremities as well as the general circulation. Plass and Rourke have shown that fibrin increased in the extremities following such measures, and as the result of such stagnation fibrinogen and thrombokinase stored in the tissue pass into the venous blood with the release of the stagnated blood, thus supplying increased agents to the general circulation with beneficial results. It is recommended that the tourniquet be applied on the thigh near the inguinal region without interfering with the arterial pulsation and should be left on for thirty to sixty minutes before being gradually released.

8. DIETARY TREATMENT

Very few exact facts are available regarding the effect of diet in this condition. The use of excessively hot or cold foods, or too large amounts, should be avoided. Condiments and stimulants should be avoided, and it is necessary to reduce the fluid intake so that it will not exceed one pint daily. The proportion of protein should be high because of its value in the formation of further coagulating agents.

9. SURGICAL MEASURES

Of the surgical measures (artificial pneumothorax, phrenic nerve block, pneumolysis, extrapleural thoracoplasty) artificial pneumothorax is most frequently used. The purpose of all these forms of intervention is to reduce the blood content of the lung tissue. It is known that injection of air into the pleural cavity will reduce the intrapleural negative pressure. Such reduction will involve a relaxation of the stretched blood vessels, together with the pulmonary tissues that are held in an expanded condition adjacent to the chest wall by the suction effect of the negative pressure under normal circumstances. Partial elimination of this suction effect, after a partial pneumothorax, will release the bronchial vessels, and in receding toward the hilum will become shorter and wider with a subsequent increase in the blood supply per unit volume of lung. Yates observed in his surgical investigations that the pressure in the pulmonary veins is so low that only branches of considerable size would produce hemorrhage even when eroded. The pressure in the bronchial artery is the same as that in the large circulation. A partial collapse, established by artificial pneumothorax, will cause an obstruction of the pulmonary artery in which the pressure is only one-fifth of that in the systemic circulation.

These facts offer us an intelligent insight into the usefulnes and technic of artificial pneumothorax in pulmonary hemorrhage. If the bleeding is coming from pulmonary vessels a so-called low tension pneumothorax, that is, the reduction of the intrapleural neg-

ative pressure from minus 5 cm. of water to minus 2 or 3 will control it. This can be accomplished by the injection of 200-300 cc. of air. The exact amount should depend upon the desired reduction of negative pressure and the therapeutic response. For practical reasoning the above statement may be reversed and it might be said that if the hemorrhage is controlled by a reduction of the negative pressure from one-third to one-half of the original reading, we are dealing with a hemorrhage from the pulmonary artery or vein.

The bronchial vessels become obliterated only by complete collapse, that is, by the total elimination of the intrapleural negative pressure or by the creation of positive pressure within the pleural cavity. It is necessary to apply this so-called high tension pneumothorax, producing complete collapse or even compression of the lung, to check hemorrhage from the bronchial vessels. The amount of air usually injected for this purpose varies from 500 to 1200 cc. It can be seen that, from the amount of induced air required for stopping the hemorrhage, one is able to determine the source of the bleeding. Using the proper amount of air, artificial pneumothorax does not retard blood or pulmonary secretion, but even aids expectoration. In the presence of hemorrhage, supposedly originating from a cavity, its collapse by artificial pneumothorax must be attempted.

When artificial pneumothorax is used for controlling hemorrhage, it should be continued for treating the underlying tuberculous process as long as it is deemed necessary according to the clinical course of the disease. The interval between refills must be shorter than in ordinary cases during the first two weeks.

It is sometimes a perplexing question which side to inflate. If the patient is known to us, it may be supposed with reasonable certainty that he is bleeding from the side with the most activity as indicated by the physical and roentgen ray findings. If the patient is first seen at the time of the hemorrhage, an examination of the anterior aspect of the chest can be made to detect its origin. In both instances, however, the subjective feeling of the patient must be taken into consideration. He will often indicate the source of bleeding by complaining of heat, an oppressive, choking sensation or a consciousness of unusual activity in the main bronchi on the side of hemorrhage.

If the desired pneumothorax can not be established because of adhesions, the cutting of these adhesions, pneumolysis, may be necessary. If pneumothorax seems to be unsuccessful or impossible, because of extensive adhesions, or when the hemorrhage is of pulmonary artery origin, phrenic nerve block should be performed. Phrenic nerve block will reduce the intrapleural negative pressure with only one-third of its original value, therefore, it will not stop the hemorrhage from bronchial vessels. An experienced surgeon when called to a hemorrhage case, will inquire as to the color of the expectorated blood, and if it is bright red, indicative of bronchial bleeding, will advise against phrenic nerve block.

In recurring, uncontrollable cases, particularly those with cavities, thoracoplasty should be thought of. All its indications and contraindications must be conscientiously considered with particular attention to the basic principle of all surgical interventions that the operation should not be too great for the patient's weakened resistance.

10. BLOOD TRANSFUSION

If the patient does not respond to any other measures, and the hemorrhage continues, blood transfusion should be undertaken. Not more than 200 cc. should be given. Whole blood is preferred because it contains more immune bodies and coagulant factors than modified blood. Transfusion can be repeated daily if necessary. In cases where transfusion cannot be given, 10 to 20 cc. of the patient's own blood can be injected intramuscularly.

SUMMARY

The purpose of this paper is to give an outline of the principles of treatment of pulmonary hemorrhage followed in our daily practice. Therefore, no mention is made of methods, drugs and proprietary preparations that have controversial, questionable or no value at all. The form of intervention should depend upon the individual case. The

psyche of the patient should not be left out of consideration. Strict discipline and good nursing are essential parts of a hemorrhage regime. As a prophylactic measure, patients with hemorrhagic tendency should have more carefully supervised exercise than others. It is true that many pulmonary hemorrhages will stop spontaneously, but there is no indicator to help us in finding out which patients belong to this group and those who will have prolonged or severe hemorrhages. The tuberculous process and the hemorrhage are indicative of the fact that these patients have poor resistance, immunity, and defense against this disease and that their tissue repair is incompetent. The loss of blood, no matter how small in amount, means loss of elements that are essential in the body's fight against tuberculosis. Omission of adequate treatment can not be justified in such a case. Measures to reduce the blood pressure should be instituted early. The retention of extravasated blood in the bronchi may lead to massive atelectasis or pneumonia. In the management of cough, codein is preferable to morphine. Cough should not be suppressed but regulated during hemorrhage. Coagulants should be used early and liberally. By the application of tourniquet we not only reduce the amount of circulating blood and the blood pressure, but also induce into the circulation the patient's own coagulants. If medical measures are not successful in checking the hemorrhage, surgical intervention in the form of artificial pneumothorax, phrenic nerve block, thoracoplasty or blood transfusion should be resorted to.

What Surgery Has to Offer the Patient with Pulmonary Tuberculosis*

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The patient suffering from pulmonary tuberculosis is no longer shackled to one form of treatment. Physiologic rest accomplished through a regulated sanatorium regimen has been the sole method to which our predecessors had access. It still remains one of the most effective weapons in our armamentarium for combating the disease; but time, along with the increasing knowledge in the treatment of these cases, has clearly proved that in certain instances its employment as the only procedure is both inadequate and ill-advised. Many patients who in the past would have remained chronic invalids or have been doomed to an early death are now receiving the benefits of very valuable and effective adjunct surgical procedures.

Between the wild enthusiasm which greeted certain of the newer methods for the surgical management of pulmonary tuberculosis and the reactionary attitude of non-intervention must lie a happy intermediate zone of moderation. As in many other advances in medicine the surgery of pulmonary tuberculosis is paying the penalty of professional distrust as a direct outgrowth of the ill-advised radicalism of some of the earlier proponents of the method. During the past twenty-five years surgery has slowly but surely crept into the treatment of the disease. In this period new methods have developed with such rapidity that even those most interested in the subjects have experienced considerable difficulty in keeping abreast with the advance. Accordingly, it would seem advisable at this time to attempt an assessment of our surgical assets in the treatment of pulmonary tuberculosis; for only by such periodic inventories is it possible to evaluate these measures and their availability to specific patients.

With any surgical procedure the physician is primarily interested in the restoration of function. At times obviously it is a matter of serious decision as to whether the advantage of a given method of treatment is sufficient to warrant the sacrifice of function. On the other hand, it may be generally accepted that a suspension of function, temporary or permanent, offers much greater chance for the control of the pathologic process than a maintenance of such function. It, therefore, behooves the physician to consider the contemplated procedure, first in the light of its

* From the University of Wisconsin Medical School.

revocability. From this standpoint the available surgical measures for the treatment of pulmonary tuberculosis may be divided into two groups, revocable and irrevocable.

A. Revocable:
   1. Pneumothorax.
   2. Temporary phrenic block.
   3. Temporary intercostal block.

B. Irrevocable:
   1. Phrenic exairesis.
   2. Scaleniotomy.
   3. Intercostal neurectomy.
   4. Pneumolysis.
      Extrapleural.
      Intrapleural.
   5. Thoracoplasty.

The major aims in the surgical treatment next arrest our attention. It is not surprising since rest is the accepted principle in the treatment of this disease that surgery should draw its first line of attack with the view of immobilizing the thoracic cage. Success in this effort would distinctly limit the blood and lymph flow from the affected lung in addition to actually reducing the circulation of air which favors the spread of the infection. The added mechanical factor of relaxation and collapse of the involved lung with the elimination of the infected secretions will decrease the toxemia and effectively promote the healing process. On the basis of these aims a division may be effected into motor and mechanical operations. These divisions overlap in that most operations of a mechanical nature interfere with mobility.

A. Motor:
   1. Phrenic block — temporary or permanent*.
   2. Scaleniotomy.
   3. Intercostal neurectomy.

B. Mechanical relaxation or collapse:
   1. Pneumothorax.
   2. Pneumothorax followed by intrapleural pneumolysis.
   3. Extrapleural pneumolysis.
   4. Thoracoplasty.

The ideal of surgical treatment, granting full control of the pathologic process, should be to insure an optimum of physiologic rest with a maximum of functional return. Hence a revocable measure should be the choice of procedures, provided it meets the indications in the given case. Artificial pneumothorax stands out distinctively in this relation as a revocable procedure having as its chief purpose the relaxation and collapse of the underlying lung and the incidental effect of inducing rest on the treated side. Phrenic block produces complete paralysis of the hemidiaphragm, the importance of which can well be appreciated when we consider that a half of the fibro-muscular septum is responsible for one-quarter of the total vital capacity. Then, too, the resultant elevation of the dome of the diaphragm induces a collateral effect — the partial relaxation and collapse of the lung. It not only serves as an adjunct but has come to occupy an assured place as an independent procedure. Its field of usefulness is restricted, chiefly due to the failure to immobilize the thorax adequately and to close cavities mechanically. Originally, it was thought to be of definite use only in basal lesions, but now its value in affecting lesions throughout the lung is established beyond doubt. This occurs despite the fact that the intercostal overactivity results when this muscular force is no longer opposed by the antagonistic action of the diaphragm and is evidenced by an increase in the costal flare and an increased undulation of the upper ribs on the involved side.

Pneumothorax, which is highly efficient when a free pleural space admits of complete separation of the lung from the thoracic wall, is limited in its usefulness because of complicating pleural effusions and the necessity for frequent refills over a long period of time. The group of subjects in which this measure is applicable, is limited by reason of the frequency of restricting pleural adhesions.

These factors have stimulated search for further motor operations which will interfere with the function of the two remaining major muscle groups of respiration, the scaleni and intercostals. A division of the scaleni which fix the upper three pairs of ribs, acts much like the release of the guy-rope on a tent. Section of the second to eleventh in-

* The elevation of the diaphragm following phrenic block obviously reduces the size of the hemithorax and thus leads to a degree of relaxation and collapse of the lung above. Hence it may be included in B also.

tercostal nerves, inclusive, effectively reduces or abolishes the movements dependent upon intercostal activation. These two motor operations while irrevocable hold a distinctly intermediate position in so far as gravity is concerned.

Intra- and extrapleural pneumolysis, two operations with only limited applicability, must be considered as somewhat more serious measures. The intrapleural pneumolysis of Jacobeus carries only the function of dividing offending adhesions which prevent the satisfactory institution of artificial pneumothorax. Extrapleural pneumolysis produces a collapse of a localized portion of the lung by the insertion of a filling of some suitable material between the rigid thoracic cage and the parietal pleura. In a limited number of cases it offers an ideal procedure for the treatment of sharply localized apical pulmonary lesions.

Thoracoplasty lies at the extreme end of the scale. Regardless of the technique employed its chief aim is to bring about the maximum collapse of a given hemithorax through the removal of appropriate sections of ribs. In certain localized lesions only a portion of the hemithorax is sacrificed, but as a rule the method is employed for those cases which demand complete collapse. Such radical collapse therapy clearly involves the functional ablation of a given lung; therefore it must never be considered where the lung has not been condemned. If cavities persist, their collapse can be frequently accomplished by more conservative procedures.

ANALYSIS OF NEEDS

With the available surgical procedures in mind. their application depends upon a careful analysis of the needs of a given patient. In a word, surgery in the treatment of pulmonary tuberculosis should be sharply individualized. The generally accepted position favors the withholding of surgical measures until a plateau of improvement under medical treatment has been attained. It is true that any plan of procedure which adopts surgery before such a level of improvement has been reached with the accustomed measures of rest and general medical care, must withstand the criticism of mixed therapy and the results will be difficult to evaluate. The feeling is growing that the revocable measures at least may possibly be applied to advantage in early cases. Temporary phrenic block has been advised in this relation. From a physiologic standpoint, to temporary phrenic block, scaleniotomy and upper intercostal neurectomy, second to fifth inclusive, may be added to insure apical rest. The thought of speeding the arrest of an incipient process would actuate this plan.

For working purposes several groupings of the tuberculous lesions have been made to facilitate the election of surgery.

A. Unilateral.
   1. Minimal.
   2. Advanced with or without cavitation.

B. Bilateral.
   1. Maximal unilateral, minimal contralateral.
   2. Equal distribution.

The most ideal case of pulmonary tuberculosis for any type of treatment is the unilateral lesion. It is in this type of lesion that the chances of error in the interpretation of mixed treatment would be greatly increased, because beyond a doubt the majority of these cases with appropriate medical treatment go on to arrest without the support of adjunct surgical procedures. The point which has already been raised is whether certain surgical measures, especially those influencing motor activity, may not enhance the processes of repair. Artificial pneumothorax, which diminishes motor activity through relaxation and compression, has long been utilized by certain workers with this thought in mind. It is, by virtue of its simplicity and gratifying results, the procedure of choice. The institution of this treatment is not always possible because of an obliterating pleurisy or existing adhesions. Phrenic block may be used as an adjunct to pneumothorax or as an independent procedure. When used as an adjunct there occurs an increased degree of relaxation and collapse with the elimination of the powerful piston-like movement of the diaphragm. This diminishes the necessity for so frequent refills and the chances of a complicating pleural effusion. Phrenic block when used as an independent

procedure is most effective in basal lesions. Its effect diminishes as the apex is approached. The intercostal muscular activity is increased throughout the entire hemithorax after phrenic paralysis. This compensatory result reduces the anticipated rest to the underlying lung. The combined operation of scaleniotomy and upper intercostal neurectomy, second to fifth inclusive, although an irrevocable measure, results in no marked functional disturbance. This combination must be seriously considered in those cases with only apical lesions where rest is of prime importance. Scaleniotomy may also be combined with a temporary intercostal block, thereby leaving only the permanent but inconsequential loss of the scalene function. If it were possible to inject the nerves to those muscle groups and produce a temporary loss of function, the difficulty would be solved.

In the case of the advanced unilateral lesion, the first question for the attending physician to answer is the repair possibility in such an extensive process. It may be impossible in the borderline cases to determine either the course or the ultimate termination of such a process without close observation over a period of months. This observation period can be abused, however, by undue prolongation when the necessity of protection to the unaffected contralateral lung is considered. This factor alone should be given considerable weight in the ultimate decision. In this type of lesion, as in the minimal unilateral process, pneumothorax is the procedure of choice because of its efficiency in promoting functional rest through relaxation, collapse, and resultant immobilization. Patients who are extremely toxic will show great improvement under this method of slow collapse. The infected secretions are gradually emptied into the larger bronchial passages and expelled. The resultant toxemia to a great degree is eliminated. The slow release of the toxic and bacteria-laden lymph prevents the sudden flooding of the same into the general circulation, thereby eliminating massive autotuberculinization which may occur in the sudden collapse of a thoracoplasty. Too much confidence cannot be placed upon pneumothorax in these cases because in the greater proportion of them it is either impossible or entirely inadequate by reason of adhesions. The effort to induce artificial pneumothorax should always be made, since at times even inadequate collapse is followed by marked subjective and objective improvement. Phrenic block, temporary or permanent, can often be utilized as an adjunct procedure and is quite effective if the complicating adhesions occur near the base or even at the apex. The paralysis of the diaphragm with its subsequent rise may permit the relaxation of these adhesions, thus freeing the splinting action previously offered and providing a more adequate collapse of the diseased lung. Phrenic block carries the added advantage of serving as a test operation to determine the integrity of the contralateral lung under its added strain. If there be doubt as to the good lung, a temporary block is advisable. The improvement following phrenic block is usually sufficient to make the procedure worth while. Careful observation may show that the degree of improvement does not accomplish complete arrest but a new plateau may be attained which renders the patient a better subject to withstand successfully a more radical type of operation. If the patient is still unable to withstand the collapsing operation, another less radical type may be decided upon which will further pave the way for added surgery, if it should eventually prove necessary, without undue risk. Multiple intercostal neurectomy with resultant paralysis of the second to eleventh intercostal muscles inclusive in conjunction with phrenic block succeeds in eliminating the function of two of the most important respiratory muscle groups. The added rest given through this procedure deserves serious thought. Its employment frequently brings about very gratifying results. Thoracoplasty, as stated before, lies at the end of the scale and through its performance collapse, relaxation, and rest are obtained. The degree of collapse is inferior to that of pneumothorax, but when employed following other motor operations which have reduced movement to a minimum, the effect is enhanced and the results are very satisfactory, provided the choice of the patient has been properly made.

In the maximal unilateral and minimal contralateral lesions a much more complex problem is presented. Both lungs have felt the ravages of the disease. The question which at once arises is whether or not the resistance of the patient is sufficient to halt the advance of the disease in the less involved lung. Casual examination will not answer this question. The patient should be placed under a rigid sanatorium regime and the progress closely followed. If after careful observation no advance is noted, and a plateau of improvement is reached, attention must at once be directed to some adjunct procedure which will carry a maximum amount of functional rest with a minimum of operative shock. Here again, as in the previously described lesions, the procedure of choice is artificial pneumothorax. The effective collapse and relaxation of the maximally involved lung produces definite therapeutic results. If possible, slowly induced collapse will diminish the toxemia as has been previously mentioned. This alone may be sufficient to increase the patient's general resistance and induce a healing of the minimal contralateral lesion. If this occurs despite the fact that more work is being thrown upon it, a clearer idea is obtained as to what future procedures may be necessary. If pneumothorax is not possible, a motor type of operation must be invoked. Temporary phrenic block should be the method of choice. This will not only give limited relaxation and collapse but will also serve as a test operation for the other lung. The temporary block is revocable and a retreat is always possible, should the result be unsatisfactory. The division of the intercostal nerves may again be of great value in giving added rest. If the maximally involved lung is hopelessly diseased and sufficient improvement or at least a stationary condition has been observed in the opposite lung, thoracoplasty may then be considered. It should not, however, be employed as a therapeutic measure in this type of case until the stability of the opposite lung has been definitely proven. To do so will give disappointing results and only bring about unfair criticism of all the surgical procedures which might have been judiciously employed.

The bilateral cases with equal distribution are the most discouraging group of cases with which medicine has to deal. Seldom are these patients candidates for operative procedures and the postoperative results are disappointing. Infrequently a patient may become eligible for one of the motor types of operation. Sufficient progress has not been made up to the present time to warrant the routine utilization of such procedures as bilateral phrenic block. Extrapleural pneumolysis may be instituted where large cavities demand mechanical collapse by reason of repeated hemorrhage. Artificial pneumothorax can be instituted, if adhesions do not prevent it, in bilateral cases but must accompany bed rest and general medical care. Until further work and study have been carried out and newer methods devised, little can be expected from the surgical treatment of this group of patients.

CONCLUSION

This analysis and application of the surgical procedures available to tuberculous patients must of necessity be arbitrary. It is furthermore offered in the knowledge that with time and growth will come many modifications and additions. For the present it simply affords perspective in evaluating ways and means for the more adequate treatment of pulmonary tuberculosis.

Roentgenologic Signs and Differential Diagnosis of the Principal Malignant Diseases of the Lungs and Mediastinum*

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The primary and secondary intrathoracic carcinomas and sarcomas, together with the lymphoblastomas, constitute an interesting field for the roentgenologist. Although in frequency of occurrence no one of them ranks with the common inflammatory diseases of the lungs and mediastinum, this entire group

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of malignant diseases has a relatively high incidence in the aggregate. All of them have deceptive roentgenologic simulants and, with the exception of malignant metastasis to the lungs, are often wrongly diagnosed.

PRIMARY CARCINOMA

Manifestations of primary carcinoma of the lung vary with the site of the growth, its stage, and the presence or absence of complications. With respect to the seat of origin, two main types are recognized, bronchial and parenchymal, although in their advanced stages they are often indistinguishable from each other.

In the early stage, bronchial carcinoma, arising in the wall of a principal bronchus, is characterized primarily by an adventitious shadow at the hilum. The shadow is unilateral, centered rather precisely at the hilum, and is either somewhat hemispherical with an ill-defined margin, or is roughly triangular with an outwardly directed apex and strand-like ramifications extending peripherally along the bronchovascular tree. Bronchial obstruction tends to occur relatively early and is evidenced by an area of atelectasis in the tributary parenchyma. Not infrequently atelectasis is the sole early manifestation, and the growth is as yet too small to cast a discernible shadow at the hilum. If bronchial obstruction has existed for a considerable time bronchiectasis may ensue with its characteristic shadows, and rarely this may be the only sign discoverable. The three signs, the shadow of a mass at the hilum, atelectasis, and bronchiectasis, singly or in divers combinations, can be taken as basic. On them are superimposed the new and confusing phenomena incident to advance of the disease and to the advent of complications presently to be mentioned.

Parenchymal carcinoma begins as a single nodule, most often in an upper lobe, but seldom if ever in the apex or in the extreme outer portion of the lobe. The nodule is more or less spherical, not at first very dense, not sharply delimited, and is surrounded by apparently normal parenchyma. As the growth enlarges, its periphery may extend to coincide with part of the lobar border, or it may become an irregularly shaped mass, or by intruding into a bronchus it may give rise to atelectasis or bronchiectasis like that associated with bronchial carcinoma, and other complications begin to appear.

The complications associated with bronchial and parenchymal carcinoma comprise chiefly pleural effusion, metastasis, and pyogenic infection. Pleural effusion is especially common and often fills the pleural sac to the extent that the underlying disease can be revealed only by examination after paracentesis. Metastasis may occur within the lung primarily affected, in the opposite lung, or in both lungs. Frequently metastasis takes the form of small satellites in the vicinity of the original mass, but the nodules may be gross and irregularly distributed, or miliary and widely disseminated. Occasionally the mediastinal lymph nodes are invaded and greatly enlarged. Pyogenic infection produces either diffuse pneumonitis or an abscess, the latter especially in complicating bronchiectasis. Cavitation may follow infection and necrosis within the primary mass. Concurrent disease, notably tuberculosis, healed or active, is not rare. All these complications have their appropriate manifestations, but their combination with pulmonary carcinoma renders interpretation extremely difficult.

The unilateral shadow of early bronchial carcinoma may be imitated in varying degree by Hodgkin's disease, ordinary mediastinal adenopathy, aneurysm, simple bronchiectasis, infiltrative metastasis from extrapulmonary carcinoma, and paravertebral abscess. When the hilar lesion is not apparent, and only atelectasis or bronchiectasis is evident, complete diagnosis cannot be expected, but pulmonary carcinoma should be considered among the potential causes. The single nodule of an early parenchymal carcinoma may be mistaken for an abscess, benign neoplasm, gumma, or solitary metastatic nodule, and no distinguishing criteria are consistently applicable. Extensive invasion of a lobe by parenchymal carcinoma is imitated by tuberculous pneumonia with caseation, save that the latter is more likely to be accompanied by obviously tuberculous lesions elsewhere in the lungs. When either bronchial or parenchymal carcinoma is accompanied by widespread

metastasis, the examiner will be inclined to assume that the source is extrathoracic, although the observation of a gross hilar or lobar mass should at least make him cautious. On the whole, although many other lesions resemble primary carcinoma, the fact that the disease is rare, and is unlikely to be considered, is perhaps the greatest obstacle to its diagnosis. However marked its resemblance to other disease, primary carcinoma usually gives rise to additional phenomena which should stimulate further investigation. Often the final diagnosis will require examination after paracentesis, roentgenoscopic studies, reexamination after an interval, active cooperation with the clinician, bronchoscopy, and biopsy.

SECONDARY

Metastasis to the lungs from malignant neoplasms in other parts of the body is common and the roentgenologic diagnosis rather seldom entails difficulty. Often the roentgenologic demonstration of secondary growths in the lungs is the sole patent evidence of disease, and the clinician is taxed to find the hitherto unsuspected primary tumor. In this connection it may be pointed out that pulmonary metastasis occurs most often from malignant disease of the breast, thyroid gland, and kidney, in that order, and much less frequently from abdominal organs other than the kidney. Metastasis to the lungs from carcinoma of the stomach has been observed but once at The Mayo Clinic. Osseous and pulmonary metastasis are not often associated.

CLASSIFICATION

From the roentgenologic standpoint the metastatic lesions may be classified as (1) nodular, (2) miliary, and (3) infiltrative. In the first variety, which is most common, the nodules are spherical and may attain a diameter of 10 cm. or more. Their shadows are clear-cut and homogeneous, and vary in density. At their earliest stage they may be few or even single, and situated in almost almost any part of the lung, but seldom in the apex. When few, the growths may be confined to one lung, but when numerous they are usually scattered irregularly throughout both lungs. Multiple nodules are likely to be diverse in size and more or less discrete, but they are sometimes of fairly uniform diameter and sometimes aggregated, although not fused, into lobulated masses. As a rule, multiple nodules are most numerous about the hilum and in the lower two-thirds of the lung, rarely invading the apexes. In the second, or miliary variety, which is encountered far less frequently than the ordinary nodular type, the nodules are extremely small and diffusely distributed. In the infiltrating type the metastasis appears to have invaded the hilar lymph-channels in retrograde direction against the flow of lymph, and is seen as a gross shadow at the hilum with branches extending out along the bronchovascular trunks. Any variety of metastasis may be attended with pleural effusion.

In the differential diagnosis, care is necessary when the nodules are early, and either single or few in number, for the shadows may be imitated by those of moles or other cutaneous lesions, the nipples, small encysted interlobar effusions, benign tumors, gummas, cysts, enlarged lymph nodes or abscesses. Advanced metastasis, with numerous large, discrete nodules, should scarcely be confounded with any other disease. The variety with aggregated small nodules has a certain resemblance to pneumonoconiosis, although the fibrous striations of the latter are lacking. Miliary metastatic lesions are hard to distinguish from those of miliary tuberculosis, although miliary tubercles are likely to be more numerous, smaller, less dense, and distributed most thickly in the upper and middle portions of the lungs. Metastatic lesions from carcinoma, hypernephroma, and sarcoma are indistinguishable from one another. Secondary lesions arising from pigmented neoplasms are usually denser than those arising from nonpigmented tumors, but this is scarcely an adequate basis for confident distinction.

Hodgkin's disease (lymphogranulomatosis), lymphosarcoma and the malignant types of leukemia may be grouped under the single generic term of lymphoblastoma, for it is often impossible to distinguish one from another either clinically or pathologically. The treatment of all is along the same lines, and the prognosis is virtually the same in all.

In studying a considerable series of cases at the clinic recently, it was found that in approximately 40 per cent of the cases of Hodgkin's disease and in about 20 per cent of the cases of lymphosarcoma, there were roentgenologically visible changes in the mediastinum and lungs.

The cases of Hodgkin's disease with intrathoracic involvement comprised two groups. In the first group, which included more than 60 per cent of the cases, only the mediastinal or hilar lymph nodes, or both, were attacked. Invasion of the mediastinal nodes was evidenced by a widened, usually lobulated, mediastinal shadow. Often the lobulation was marked, but sometimes it was slight. The density of the shadow was usually about the same as that of the normal mediastinum, save that the outer margins were somewhat fainter. In the majority of cases the involvement was bilateral, but in many it was unilateral. The trachea was displaced in but one case of the series. In addition to the mediastinal shadow, discrete shadows representing the hilar nodes were seen in about 20 per cent of this first group. The second, smaller group, was characterized by pulmonary invasion in combination with involvement of the mediastinal and hilar nodes. Most frequently encountered in the second group was the picture of infiltration into the lungs, originating from the affected nodes. The appearance varied, and was sometimes that of bronchiectasis, or bronchopneumonia (save that the patches were denser), or metastasis, or even of primary carcinoma. Extensive involvement of the lung seemed to be a late complication, for it was confined to cases of well advanced disease among patients whose condition was poor. Pleural effusion occurred in some cases, but was not common.

The same manifestations and grouping applied also to the cases of lymphosarcoma. All exhibited mediastinal or hilar involvement of the nodes, and pulmonary invasion was added in a minority. The phenomena in the cases of leukemia were practically identical with those observed in Hodgkin's disease and lymphosarcoma.

In a review of the three varieties of lymphoblastoma it would appear that there is no distinguishing roentgenologic sign of any of them. Any of the three may exactly resemble either of the others, and, in view of their morbid anatomy, this might be expected. All that can reasonably be expected of the roentgenologist is a diagnosis of lymphoblastoma, and this has its difficulties and sources of error.

The differential diagnosis must take into account aneurysm, benign tumors, substernal goiter, malignant metastasis, tuberculosis, and perhaps other disease. Roentgenoscopy may aid in excluding aneurysm and goiter. Not rarely an exact diagnosis can be reached only by correlation with the clinical facts. If this fails, the therapeutic test with roentgen rays may be decisive.

DISCUSSION

Dr. James T. Case (Chicago): I am sure I am voicing the opinion of all present when I express my appreciation of the excellent discussion we have just heard. Dr. Kirklin has handled the subject matter very succinctly and completely, and we have all been instructed.

I am struck by the frequency with which acute infections may mask the x-ray characteristics of mediastinal tumors, especially when branches of the bronchial tree are compressed, with resultant atelectasis of greater or lesser extent, confusing materially the diagnosis of the primary lesion.

The author has very properly referred to bronchoscopy. I wish to emphasize its value as a supplementary examination to be used in connection with roentgen ray studies. Doubtless the author has also in his paper referred to the use of lipiodol; I find it very useful as an adjunct in helping to differentiate between the various types of mediastinal and pulmonary tumors.

Dr. Kirklin mentions one case of carcinoma of the stomach, with metastasis to the lung. I have had one similar case with metastasis to the lung, bone, and even multiple tumors of the skin.

Screen examination is too valuable in chest studies to be omitted when there is any question of mediastinal involvement. Sometimes the screen study is more valuable than the film studies. This seems paradoxical, but it is true that once in a while certain important details of value in the differential diagnosis appear more clearly on the screen than on the film record.

As the speaker has explained, it is important to realize that it is not possible to distinguish metastatic carcinoma from metastatic sarcoma by the morphological character of the metastatic patches in the lung. Formerly it was the opinion that sarcoma appeared in rounded, more or less clean-cut nodular metastatic patches, thus distinguishable from carcinoma which was supposed to appear in

more or less fuzzy patches. This erroneous idea still persists in some quarters and should be corrected. We know now that carcinoma, sarcoma, and hypernephroma may cause a very similar appearance in the lung when metastasizing.

The numerous beautiful slides shown by the author demonstrate the anteroposterior aspect of the lesion and do not suggest that he attributes much value to the lateral and oblique studies. I know that he does value these lateral projections and I merely mention this matter to bring out the fact. I believe mention was not made of thymoma. Thymoma is a mediastinal tumor of importance and usually distinguishable in the lateral films because of its anterior position in the upper mediastinum.

The therapeutic test is often of value in differentiating in these tumors. The lymphomas usually subside or reduce materially in size under x-ray therapy; whereas, the other types of pulmonary and mediastinal tumors do not respond so dramatically.

One cannot close this discussion without wondering if the author has anything new to present concerning the cause of the increased frequency of carcinoma of the lungs. I recall that in a recent discussion on this subject the idea was advanced that the increased use of tar compounds in hardening roads plus the increased use of the automobile resulting in more inhalation of tar products in dust might be one of the causes of the increase in the frequency of carcinoma of the lung.

THE JOURNAL CLINIC

Diaphragmatic Hernia; With Report of Case

By EVERETT B. KECK, M. D.
Madison

Diaphragmatic hernias are classified among the rare conditions. With the advent of x-ray, the diagnosis is more easily made and more cases have been reported within the last few years than formerly. The first cases were reported in 1610 by Ambrose Pare, and up to 1846 only 88 cases had been reported. Literature on this subject has been well reviewed in an excellent article by Carl A. Hedblom, appearing in the Journal of American Medical Association of September 26, 1925.

The classifications are many and varied, but the one of Lilenthal seems to be the most satisfactory and simple. He divides them into congenital and acquired hernias and subdivides these into true and false—true hernia in which there is a sac and false hernia where there is no sac.

The etiological factor in congenital hernia may be a congenital absence of, or defect in, the diaphragmatic musculature, or to relaxation about the various hiatuses. In the acquired type, the most common cause is traumatic, such as knife wounds, bullet wounds and other wounds common in war. In the report of 315 cases, only six were caused by lifting, three by parturition, one by a fall, and one from whooping cough.

Of the viscera most commonly found in the hernial sac the stomach is the most frequent. Some 333 cases reported by McLean found the stomach present in 187 instances, small intestines in 133, spleen 78, liver 60, duodenum 48, caecum 35, colon 17, pancreas 12, left kidney 2, right kidney 1.

The following case which I wish to report has one interesting factor in that I have been unable to find in the literature a case with a similar etiological factor.

CASE REPORT

Miss B. is a well developed, undernourished, white female, 60 years of age who upon observation appears to have lost considerable weight. Hospital history is as follows:

C. C. Burning in epigastrium, food idiosyncrasy, vomiting and nausea, and loss of weight.

H. P. I. Onset of above symptoms began four months ago and have been gradually increasing in severity. First symptom was that of burning in the epigastrium which radiated downwards through the entire abdomen. This sensation would begin within an hour after eating and continue for one hour. Heavy food caused the pain to be more persistent. Some relief was obtained from the use of alkalies.

The onset of the nausea and vomiting occurred a few weeks later and has been increasing in severity until at the present time

the vomiting occurs as soon as the patient starts to eat. During the last few days the vomiting has occurred every few minutes even though no food was taken.

During the past two months the patient has lost 30 pounds in weight and there has been a proportional weakness.

History by systems was essentially negative except for some urinary disturbance. Menopause four years ago. Pneumonia one year ago.

Physical examination revealed temperature 99, pulse 92, respirations 20, and blood pressure 142-84; head and neck normal; heart showed only a roughened first sound; tactile fremitus was somewhat decreased over the left chest. The abdomen was large and protruding with a sensation of a smooth tumor mass entirely filling it to the ziphoid. There was no palpable fluid wave or any nodules. The only tenderness was found in the epigastrium and then not marked. Vaginal examination was negative except for a bulging downward in the posterior culdesac.

A tentative diagnosis of ovarian cyst was made but carcinoma of the stomach with possible carcinomatosis was considered.

Laboratory reports were as follows:

C. B. C. W. B. C.—11,840; R. B. C.—4,610,000; Hemoglobin 65%; differential count within normal limits; blood sugar — 109 mgrms. per 100 c. c.; N. P. N.—30 mgrms. per 100 c. c.; Wassermann test was negative; urine showed a trace of albumin, few white blood cells, and stool examination was negative.

Ewald Meal—Free HCL 8; total acid 42.

The x-ray examination of the G. I. tract revealed a hernia about the size of an orange through the esophageal opening of the diaphragm, a diverticulum in the second portion of the duodenum, displacement of small bowel, caecum and terminal ileum by an intra-abdominal tumor. The barium enema corroborated the gastro-intestinal plate as to the tumor mass.

It was believed that the tumor was causing most of the symptoms and its removal was planned first. At operation an extremely large tumor was removed. It was multilocular in type with solid contents. The pathological report was that of pseudomucinous cystadenoma.

At the time of operation two fingers were easily inserted into the diaphragmatic hernia, posterior and to the right of the esophageal hiatus.

The patient's convalescence was uneventful and there was immediate relief of all gastric symptoms. Two weeks after operation a fluoroscopic examination of the stomach was made. The report follows:

"After ingestion of barium the stomach has resumed its normal position in the abdomen. The greater curvature is slightly above the level with the crest of the ileum. There is no evidence of a herniation at the esophageal opening of the diaphragm. With the patient in recumbent position and on deep inspiration there is a herniation about the size of a hen's egg through the esophageal opening of the diaphragm. Practically the entire cardiac portion of the stomach, however, remains beneath the diaphragm. Compared with last examination the hernia is about ¼ the previous size."

Two months after operation the patient has gained 25 pounds in weight and has been entirely free from gastric symptoms.

Due to the patient's age and apparent return to good health, operation upon the hernia was considered inadvisable.

Traumatic Appendicitis; With Report of Case

By LOUIS MILSON, M. D.
Green Bay

There has been considerable controversy in the literature, both here and in Europe, regarding the role of trauma in appendicitis. Some doubt entirely the possibility of a traumatic appendicitis; others admit that trauma can be a factor in causing an exacerbation of a previously inflamed appendix, but deny the possibility of trauma being the primary etiological factor in traumatic appendicitis. However, abundant evidence at operation, as well as experimental observation, proves the existence of traumatic appendicitis.

According to Von Neuman[1], trauma is a factor in about 6% of cases of appendicitis.

Furbinger and Von Hansemann[2] showed experimentally that when the contents of a full cecum were expressed into an obstructed appendiceal lumen by light manual pressure over the cecum, rupture of the mucosa resulted with extravasation and infection. Van Buren, experimenting on dogs, found that increased intraintestinal pressure caused pressure hemorrhage at the antimesenteric surface of the intestine. Clinically he studied the condition in cases of mechanical ileus, and observed perforation on the antimesenteric surface of the intestine near the point of obstruction. Lutz and others have shown at operation that perforation has followed severe trauma to right lower abdomen, the area of appendiceal perforation showing hemorrhagic appearance, both grossly and microscopically. According to Behan[3], the intraluminary pressure of the appendix may be increased by any force which decreases the intra-abdominal space. A force, such as a sudden blow on the abdomen, will cause contraction of the abdominal muscles, forcing cecal contents out into an obstructed appendiceal lumen causing distention and rupture of the mucosa with resulting infection.

The presence of foreign bodies in the lumen of the appendix, such as pins and seeds, may predispose to traumatic appendicitis. This, accompanied by obstruction causing congestion and oedema of the walls of the appendix, will lead to gangrene and perforation.

There have been a number of cases of traumatic appendicitis reported in the literature both here and in Europe. Bissel[4] reported four cases of perforative appendicitis coming on immediately following injury to the lower abdomen and concluded that trauma is often a precipitating cause in appendicitis. Taylor[5] reported two cases where attacks were brought on by trauma, one by a blow and the other by severe abdominal strain. Lipton[6] reported a case of appendicitis coming on following accidental injury to the right lower abdomen. Evidence at operation showed that infection took place due to a bruised and over-distended appendix. Lutz[7] reported a case of traumatic appendicitis in a boy aged fifteen, the attack coming on immediately following injury. Operation revealed a ruptured appendix with evidence of trauma and hemorrhage in the appendix and mesentery. Oden[8] and Hartoch[9] reported cases respectively. In the latter case, operation immediately following injury revealed blood oozing out of an area of appendiceal perforation.

The case reported below is of interest for several reasons: 1. Direct trauma to appendiceal region. 2. Immediate onset of symptoms. 3. No history of previous attack. 4. Good health of patient before accident. 5. Pathologic evidence at operation.

CASE REPORT

In November, 1929, a young man was brought to St. Mary's hospital complaining of severe pain over right lower abdomen which had come on immediately following a car accident. Patient was thrown with great force hitting right lower abdomen against door handle of car. He felt something "give" in his right side and immediately experienced sharp, excruciating pain over right lower abdomen accompanied by nausea. It was in this condition that he was brought to the hospital right after the accident.

Past history was negative for any previous abdominal complaints and he was in perfect health prior to the time of the accident.

General examination showed a young man aged 19, normally developed and fairly nourished, appearing acutely ill. Temperature was 99, pulse 100, respiration 26. Examination of head, neck, chest, and extremities was practically negative.

Abdominal examination showed extremely rigid and tender right lower abdomen with maximum rigidity and tenderness at McBurney's point. Urine examination was negative for blood and otherwise, both grossly and microscopically. White blood count was 14,000.

Exploratory abdominal operation the next morning failed to reveal any injury to other abdominal viscera. However, vermiform appendix was found to be acutely congested and thickened. A large fecalith was found obstructing appendiceal lumen, its edges hav-

(Continued on page 136)

THE WISCONSIN MEDICAL JOURNAL

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EDITORIALS

PEPTIC ULCER

EXPERIENCES with peptic ulcer have led to certain conclusions—some negative, some positive. Among the negative ones: that the etiology is unknown and that the symptomatology may vary extremely; from a perforated or an hemorrhagic ulcer, in which there are no previous symptoms, to all the classical manifestations, and yet, at autopsy or operation, no ulcer may be demonstrable. We also find that alkaline or neutralizing treatment, diet, rest, and so-called medical management; gastroenterostomy, pyloroplasty, local destruction or removal, and extensive pylorectomy are all followed by rather disconcerting percentages of unsatisfactory results.

On the positive side: there are many evidences pointing towards the conclusion that peptic ulcer is a local manifestation of a general disease; if not a general disease, at least a general disturbance. That this disease, or disturbance, is distinctly characterized by remissions, and that recurrences may follow prolonged remissions which greatly confuse attempts at evaluating different treatments.

Another point is that the proper treatment of peptic ulcer is not surgical or medical. It is surgical and medical with another factor, the cooperation of the patient. These must be combined to properly conduct, manage, or treat a case of peptic ulcer.

Peptic ulcer is usually found with hydrochloric acid. Peptic ulcer is not found—at least, it is so rare that it may be considered negligible—in a true achlorhydria or an achlorhydria in pernicious anemia.

The finding of peptic ulcers in Meckel's diverticulum, where the acid-secreting cells occur far down in the ileum, shows the very important relationship between acid and ulcer. Recurrent ulcers are said to occur in the absence of hydrochloric acid, but that, of course, brings up the debatable question as to whether these recurrent ulcers are accompanied by a true or a false achlorhydria.

New treatments, usually variations of old ones, are common and suggest the present unsatisfactory status of the treatment. There has appeared in the recent literature a new *principle* in the treatment of peptic ulcer, and that principle is the prevention, or an attempt to prevent, the formation of hydrochloric acid, rather than the old principle of alkalinizing, neutralizing or combining the acid *after* it has been secreted. This may be accomplished in various ways. From a medical standpoint of view: Silver and Katz, in Baltimore, a few months ago presented a substitute for sodium chloride in the treatment of peptic ulcer. Scientific, rational dietotherapy is coming much more into prominence as is shown by increasing attention being given to the vitamins, the deficiency diseases, and by the enthusiasm that

followed the so-called Gerson-Sauerbruch-Hermansdorfer diet in tuberculosis. Another way in which this desirable result may be secured is that of x-ray treatment, but in this the short-comings or limitations make it of doubtful usefulness. The surgical methods include division of the vagi, upon which reports vary; and that of removing the fundus of the stomach instead of the antrum. The difference between the fundus and the antrum has been demonstrated from an embryological, anatomical, histological, and from a chemical or physiological standpoint. There is a marked difference.

In the methods based on the old principle. the alkaline secreting antrum, and the very delicate, important, antro-pyloro-duodeno-neuro-muscular mechanism which controls the acid base balance of the body (as shown in the alkalinity of the urine and the CO_2 combing power of the expired air after gastric secretion) has been thrown away; and the acid-secreting portion, the fundus, has been retained. Newer methods that have been developed in treating recurrent ulcer are largely new, in that more and more of the fundus is removed. In an attempt to carry out the new principle, it has been recommended, in cases in which there is no organic pyloric obstruction, that the pylorus be allowed to remain and the acid-secreting portion of the stomach be removed.

In the treatment of peptic ulcer it would seem that something more than mere neutralization is necessary. Finally, satisfactory treatment based upon rational therapy will have to await an exact etiology, and this exact etiology has not, as yet, been demonstrated. F. G. C.

EVEN HIS BEST FRIEND COULD NOT TELL HIM

ROBERT BURNS revealed a deep insight into one of his own as well as humanity's deepest necessities when he said, "Oh wad some power the giftie gie us, to see oursel's as ithers see us." Perhaps the nearest approach to this divine attribute is granted to those of us possessing friends who are free to express their honest opinion of what sort of impression our words and actions have upon others.

We are all so deeply absorbed in our own problems and usually find our own viewpoint so plausible that a proper perspective is easily lost. And thereby we occasionally fall into grievous error. Fortunate is the man who keeps the door open for friendly suggestions and corrections for usually they are offered in a desire to help. Unfortunate indeed is the individual who builds up a resentful or antagonistic wall of defense against such criticism for he will soon hear little of it. He may in self complacency not sense the effect of this attitude upon his associates, but eventually the forfeiture of these opportunities for proper orientation in his work and with his colleagues will be a source of keen disappointment. A very important attribute of a well rounded character is the capacity to invite and accept in the spirit given justified criticism. J. H.

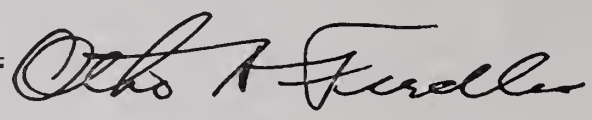
WISCONSIN AND MICHIGAN

"THE State Societies of Wisconsin and Michigan are to be heartily congratulated for their pioneer efforts in their respective states to ascertain the basic facts which underlie the most important problems facing the profession today."

This statement by Dr. R. G. Leland, director of the bureau of medical economics, American Medical Association, holds a significance for every member. It is a confirmation, if one were needed, that the work outlined for the current year by President Fiedler is of a fundamental nature. We anticipate that in the final analysis these efforts will be productive of greater results to the profession in Wisconsin and Michigan than any other work accomplished in recent years.

It will be of interest to our readers to know that in Michigan it is anticipated that upwards of $25,000 will be used in their survey efforts in that state. Such work may well be said to be preventive medicine in its broadest aspects. It is the effort to accomplish the best interests of a profession that we may perfect the means through which our people may obtain adequate services in ways that are best devised to supply their needs. J. G. C.

THE PRESIDENT'S PAGE



UNION IS STRENGTH

AESOP relates the following fable: "A Husbandman who had a quarrelsome family, after having tried in vain to reconcile them by words, thought he might more readily prevail by an example. So he called his sons and bade them lay a Bundle of Sticks before him. Then, having tied them into a fagot, he told the lads, one after the other, to take it up and break it. They all tried, but tried in vain. Then, untying the fagot, he gave them the Sticks to break one by one. This they did with the greatest ease. Then said the father: 'Thus you, my sons, as long as you remain united, are a match for all your enemies; but differ and separate, and you are undone.' Union is strength."

It would be most advantageous if an analogous demonstration could be presented to all medical men to bring home to them the lesson that in association with their confreres lies the strength of the profession. The training of the doctor is essentially to produce a man who is independent in action and thought. It often results in an individualism that brooks no interference, and occasionally leads to an egotism that is detrimental alike to the individual and the profession as a whole. There are many problems in medical practice that are group and not individual problems. Such can not be solved except by united action.

Medical associations are much more loosely organized than were the old time guilds, and have a much less rigid discipline than do the labor organizations of the present. As a consequence there are rather frequent infractions of the code of ethics in our inter-relationships and frequent instances of disregard of agreements entered into for the best interests of all concerned.

Physicians are very anxious to improve their professional knowledge and this is most commendable. In justice it must be said that probably no other professional group devotes so much time and energy to self improvement. This has resulted in the development of a profession which is undoubtedly better trained to deliver the services for which it is organized, than any other profession. But this very inclination leads us to seek membership in limited organizations or clubs which are interested not in the progress and program of general organized medicine, but in some one field of scientific medicine. We join surgical, obstetrical, gynecological, pediatric, urological, or a score of other organizations, attend their meetings and strive to improve our scientific knowledge in special fields of endeavor, forgetting that we owe a larger duty to the medical profession as a whole. We give our allegiance, our time, and our thought to the special group while we neglect the general one and fail to affiliate ourselves with, give our energies to, and secure the growth and development of the larger body represented in our county, state, and national organizations.

Societies in special fields of medicine are not concerned with the social or economic aspects of medical practice and still these aspects are very important to every doctor of medicine. Especially in periods of grave economic depression when all institutions, established social systems and economic methods are under scrutiny with the view to changes looking to the amelioration of the existing conditions, must we be alert, watchful, and on guard that changes detrimental alike to the profession and the public in its relation to medicine, are not suddenly and inadvisedly launched.

It is especially at this time, then, that every man in the profession should be drawn nearer to his colleagues and definitely group himself into our great Society which alone of all medical organizations concerns itself with the public relation of the doctor, and which maintains and uses the established machinery of the national association and its component societies in the state and county. Thus by cooperation may each become part of that fagot which shall give the profession the power to shape its own destinies in this State and in the nation. Let us not forget that in Union there is Strength.

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Wood	F. X. Pomainville, Wisconsin Rapids	W. G. Sexton, Marshfield.

SOCIETY PROCEEDINGS

COLUMBIA

Dr. K. A. Snyder, Portage, was elected president of the Columbia County Medical Society at a recent meeting held in Portage. Dr. H. M. Caldwell, Columbus, was elected vice-president; Dr. Harry Y. Fredrick, Westfield, secretary and treasurer, and Dr. H. E. Gillette, Pardeeville, delegate.

At this meeting Dr. C. W. Henney, Portage, gave a report on the meeting of the House of Delgates of the State Medical Society of Wisconsin held at the time of the annual meeting in September, 1931.

GREEN LAKE–WAUSHARA–ADAMS

At a meeting of the Green Lake–Waushara–Adams County Medical Society held in Berlin on December 17th, the following officers were elected:

President, Dr. George E. Baldwin, Green Lake; Vice-President, Dr. S. L. Casper, Berlin; Secretary-Treasurer, Dr. A. J. Wiesender, Berlin; Censor, Dr. G. G. Mueller, Princeton; Drs. Baldwin and Wiesender, delegates to the annual meeting.

The principal speaker at this meeting, which was preceded by a six-thirty o'clock dinner, was Dr. R. C. Blankinship, Madison, who spoke on "Some Unusual Gastrointestinal Diseases."

MILWAUKEE

The monthly meeting of the Medical Society of Milwaukee County was held jointly with the Milwaukee Neurological Society at the Milwaukee County Hospital for Mental Diseases on Friday, January 8th.

The hospital was host at a dinner for members of the two societies, after which the following program was presented:

"The Fever Treatment of Cerebral Spinal Syphilia" by Dr. M. Kasak, clinical director, Milwaukee County Hospital for Mental Diseases.

"The Psychiatrist's Responsibility to the Public" by Dr. Andrew I. Rosenberger.

There were 200 present.

OUTAGAMIE

Dr. E. F. Mielke, Appleton, was elected president of the Outagamie County Medical Society at its annual meeting held at Hotel Northern, January 5th. Dr. W. J. Frawley, Appleton, was named vice-president, and Dr. R. V. Landis, Appleton, was re-elected secretary and treasurer.

A committee composed of Drs. V. F. Marshall, J. B. MacLaren, and E. F. McGrath, all of Appleton, was appointed to take charge of a trust fund, and it was decided to name a public relations committee. This committee will be in charge of all public education, lectures, and state legislation sponsored by the group.

Sixty-two were present at the dinner which preceded the meeting.

RACINE

The annual meeting of the Racine County Medical Society was held at the Racine Elks Club on Thursday evening, December 17th, at eight o'clock.

Dr. F. E. Simpson of Chicago addressed the meeting on the subject of "Radium Treatment in Malignancy." The lecture was illustrated with lantern slides and motion pictures.

Officers elected for 1932 are the following: President, Dr. C. O. Schaefer; President-Elect, Dr. W. C. Roth; Vice-President, Dr. B. H. Holmes; Secretary, Dr. Susan Jones; Delegate, Dr. H. B. Keland; Alternate, Dr. L. E. Fazen; Censor, Dr. F. C. Christensen, all of Racine.

Drs. F. A. Wier, C. K. Hahn, A. J. Williams and L. N. Schnetz were admitted as members to the Society.

The regular meeting of the Society was held January 21st, 1932.

County Judge J. Allan Simpson gave a talk on "The Admission of Patients to County Hospitals as County Charges". Dr. C. C. Edmondson of Waukesha spoke on "Diabetes," and Dr. Russell Kurten read a paper on "The Physiology of the Sex Cycle."

A board of directors was chosen, consisting of the president, Dr. Carl O. Schaefer; the secretary, Dr. Susan Jones; the retiring president, Dr. J. F. Bennett of Burlington, and two members selected from the floor, Dr. L. E. Fazen and Dr. E. Von Buddenbrock.

President Schaefer introduced Dr. I. F. Thompson, recently named Racine health commissioner, who was welcomed in the name of the society. Dr. Schaefer said the society would co-operate with Dr. Thompson in his assigned work. S. J.

RICHLAND

At the regular meeting of the Richland County Medical Society on January 7th the following officers were elected for 1932: President, Dr. W. C. Edwards, Richland Center; Vice-President, Dr. L. L. Hines, Rockbridge; Secretary-Treasurer, Dr. G. Benson, Richland Center; Censor, Dr. W. R. Coumbe, Richland Center; Delegate, Dr. George Parke, Viola; Alternate, Dr. B. I. Pippin, Richland Center.

At this meeting, Dr. W. R. Coumbe discussed his observations of the use of attenuated tuberculi bacilli in France for the prophylaxis of tuberculosis in children. Dr. B. I. Pippin discussed recent knowledge in the treatment of asthma and hay fever.

Following the meeting, the nurses of the Richland Hospital served an oyster stew to members.

W. C. E.

ROCK

Dr. G. S. Metcalf, Janesville, was elected president of the Rock County Medical Society for 1932 at a meeting held in Beloit at the Hotel Hilton. Dr. F. E. Brinckerhoff, Beloit, was chosen as vice-president and Dr. E. C. Hartman, Janesville, was named secretary-treasurer.

Judge J. G. McWilliams was the principal speaker at this meeting.

WALWORTH

The members of Walworth County Medical Society met for dinner at the East Troy House on Tuesday, January 12th. Following this, Dr. Carl Henry Davis of Milwaukee presented a most interesting and practical talk on "Trichomonas of the Vaginal Tract" illustrated with motion pictures. A short business meeting followed. V. S. D.

WINNEBAGO

The Winnebago County Medical Society met in Oshkosh for its annual meeting. Officers elected were: President, Dr. G. E. Forkin, Menasha; Vice-President, Dr. D. G. Hugo, Oshkosh; Secretary-Treasurer, Dr. M. C. Haines, Oshkosh; Delegate, Dr. J. W. Lockhart, Oshkosh; Alternate, Dr. Ronald B. Rogers, Neenah, and Censor, Dr. A. G. Koehler, Oshkosh.

WOOD

The annual meeting of the Wood County Medical Society was held at Marshfield on January 5th, and the following officers were elected: President, Dr. F. X. Pomainville, Wisconsin Rapids; Vice-President, Dr. K. H. Doege, Marshfield; Secretary and Treasurer, Dr. W. G. Sexton, Marshfield; Delegate, Dr. F. X. Pomainville; Alternate, Dr. K. H. Doege; Censors, Dr. H. A. Vedder, 1933; Dr. R. P. Potter, 1934; Dr. F. X. Pomainville, 1935.

The applications of Dr. Otto A. Backus, Nekoosa, and Dr. Frank A. Boeckmann, Marshfield, were both approved and accepted.

The following program was given:

"Circulation of Cerebrospinal Fluid" by Dr. H. H. Milbee.

"Localization of Brain Tumors," by Dr. L. A. Copps.

"Localization of Lesions in Peripheral Nervous System" by Dr. K. H. Doege. W. G. S.

MILWAUKEE ACADEMY OF MEDICINE

The annual meeting and election of officers of the Milwaukee Academy of Medicine was held at the University Club on Tuesday evening, January 12th. Dinner was served at six-thirty o'clock.

Officers elected are the following: President, Dr. R. W. Blumenthal; President-Elect, Dr. D. E. W. Wenstrand; Secretary, Dr. N. Warren Bourne; Treasurer, Dr. Ralph P. Sproule; Librarian, Dr. Eugene A. Smith; Vice-President; Dr. C. H. Stoddard. Council members selected were: Drs. H. R. Foerster, J. J. Pink, John O. Dieterle, E. W. Miller, Ralph E. Morter and Carl W. Eberbach. Dr. Francis D. Murphy was chosen membership committeeman.

The regular meeting of the Society was held on Tuesday evening, January 19th, the following program being presented:

"Bilateral Paralysis of the Recurrent Laryngeal Nerve Following Thyroidectomy" by Dr. John B. Hitz.

"X-Ray Diagnosis of Postoperative Intestinal Obstruction" by Dr. D. V. Elconin.

"The Laboratory and the Practice of Medicine" by Dr. C. H. Bunting of the University of Wisconsin.

MILWAUKEE ORTHOPEDIC

The Milwaukee Orthopedic Club met on January 13th. Dr. John W. Powers was elected president for the year. Dr. Lemuel D. Smith was re-elected as secretary and treasurer.

MILWAUKEE OTO-OPHTHALMIC

The annual meeting of the Milwaukee Oto-Ophthalmic Society was held on Tuesday evening, January 19th, at the Wisconsin Club. After the dinner at 6:30 P. M., the following officers for the ensuing year were elected: President, Dr. T. F. McCormick; Vice-President, Dr. J. B. Marks; Secretary and Treasurer, Dr. O. P. Schoofs.

The scientific program presented was as follows:

"Some Neglected Details in Refraction," Dr. F. H. Haessler.

"The Use of Iodine in Infections of the Middle Ear," Dr. W. G. Merrill, Wisconsin Rapids.

"The Common Form of Ethmoiditis," Dr. B. S. Hill, Kenosha.

MILWAUKEE ROENTGEN RAY

A meeting of the Milwaukee Roentgen Ray Society was held Monday evening, January 4th, at the Wisconsin Club. The scientific part of the program was featured by interesting case reports by every member present. The following officers were elected for the ensuing year: Dr. Frank Mackoy, President; Dr. Hans Hefke, Vice-President; Dr. Edwin Habbe, Secretary and Treasurer. J. E. H.

NOTICE OF AMENDMENT

Pursuant to Article XIII of the Constitution, the Secretary reports that the following amendments to the Constitution, proposed by Dr. Spencer D. Beebe of Sparta, will receive action at the 1932 meeting of the House of Delegates.

Amend Article V "House of Delegates" to read:

"ARTICLE V

"House of Delegates

"The House of Delegates shall be the legislative body of the Society and shall consist of delegates elected by the component county societies. The officers of the Society enumerated in Section I of Article IX of this constitution, and past presidents of the Society, shall be ex-officio members of the House but without right to vote."

THE WOMAN'S AUXILIARY

Mrs. Orvil O'Neal, Ripon, Editor

A report of our activities is to be made to the National Press and Publicity Chairman at the end of the year. In order to make this interesting and a report of which we may be proud, it is very necessary that we all work together, each one doing her part, each chairman reporting promptly and fully all activities.

In this way we may also have an interesting page in our State Medical Journal. The reports sent in by the Press Chairman goes to make these pages.

We urge everyone to read the Auxiliary pages in the State Medical Journal and the Auxiliary pages in the Bulletin of the American Medical Ass'n.

All Wisconsin news items should be sent to Mrs. Orvil O'Neal, Ripon, Wis., State Press and Publicity Chairman.

May our work stand as a living example of that team-work which Kipling describes as follows:

"It ain't the guns and armament
Nor funds that they can pay,
But the close cooperation
That makes them win the day.

It ain't the individual,
Nor the army as a whole,
But the everlasting team-work
Of every blooming soul."

* * *

On Dec. 17th the ladies auxiliary of the Green Lake-Waushara-Adams Medical Society met with the doctors for a six-thirty dinner at the Grand View Hotel, Ripon.

Following the dinner the ladies proceeded to the home of Dr. and Mrs. J. M. Johnson where a short business meeting was held.

Mrs. G. G. Mueller of Princeton was received as a new member.

Election of officers for the ensuing year was as follows:

President, Mrs. B. E. Scott, Berlin.
Vice-Pres., Mrs. G. G. Mueller, Princeton.
Secretary, Mrs S. L. Casper, Berlin.
Treasurer, Mrs. J. M. Johnson, Ripon.

Mrs. C. U. Senn, Ripon, was appointed Press and Publicity Chairman.

Mrs. S. L. Casper read an interesting article on Common Defects of Children.

Following a business meeting the doctors joined the ladies and a social evening of bridge was enjoyed. Honors were awarded to Dr. and Mrs. Orvil O'Neal.

The Auxiliary met again in Berlin on Jan. 15th, where the members and the doctors had an excellent dinner at Hotel Whiting. The doctors remained at the hotel for their meeting and the Auxiliary members went to the home of Dr. and Mrs. B. E. Scott.

A business meeting was held and Mrs. A. J. Weisender was appointed Hygeia chairman with subchairmen in other towns to assist her. It is hoped thereby to increase the circulation of Hygeia.

The lesson for the evening, Contagious Disease Control, was ably presented by Mrs. Paul L. Eisele, followed by a discussion by the members.

The Doctors joined us later for a social evening of bridge. Honors were awarded to Mrs. O'Neal and Dr. Casper.

* * *

The Columbia County Auxiliary met at Hotel Portage, Dec. 10th, for a six o'clock dinner with the Medical Society.

After dinner election of officers for 1932 was held. The following were elected:
President, Mrs. J. R. Kellogg.
Vice-Pres., Mrs. K. A. Snyder.
Secretary, Mrs. H. E. Gillett.
Treasurer, Mrs. J. W. MacGregor.

After the business meeting the remainder of the evening was spent in playing cards.

* * *

The Marinette-Florence County Auxiliary met Dec. 5th at the home of Dr. and Mrs. T. J. Redlings.

Five members were present, and the following officers were elected:

President, Mrs. J. V. May, 1421 Grant St., Marinette.

Vice-Pres., Mrs. Francis DeSalvo, Niagara.

Secretary, Mrs. T. A. Lid, 1602 Main St., Marinette.

Treasurer, Mrs. M. D. Bird, 1520 Main St., Marinette.

* * *

There has been no meeting of the Rock County Auxiliary since October. At this meeting it was voted that the sum of $25 be given to the Pinehurst Sanatorium as a Christmas gift from the Auxiliary. The 1932 officers are to be elected at the January meeting.

* * *

The Woman's Auxiliary to The Medical Society of Milwaukee County held its second luncheon meeting on January 8th at the Hotel Astor.

The following officers were elected: President-elect, Mrs. Rock Sleyster, Wauwatosa; Directors, Mrs. L. F. Jermain, 1932-33; Mrs. G. E. Seaman, 1932-33; Mrs. J. B. Mathews, 1932; Mrs. J. F. Blair, 1932; Mrs. Edward Jackson, 1932.

The speakers for this meeting were Dr. Robert Blumenthal, chairman of the educational committee of The Medical Society of Milwaukee County, who spoke on "The Relation Between the Medical Pro-

fession and the Public," and Mr. J. G. Crownhart, Secretary, the State Medical Society, whose subject was "Legislation Problems of the Medical Profession."

There were 150 present.

* * *

Mrs. Henry J. Gramling, president of the Woman's Auxiliary to the State Medical Society of Wisconsin, addressed the Parent-Teacher Association of the Mercy High School on January 11th.

* * *

FROM THE NATIONAL PRESIDENT

Dear Auxiliary Members:

As we cross the threshold of a new year shall we, like other businesses, pause and take stock of ourselves to see where we have arrived in relation to the goal which we set for ourselves at our annual meetings?

Is there yet a county or a state Auxiliary that is not working under the direction of an advisory council or counselor of doctors appointed by its medical society? A questionnaire sent last summer to our thirty-seven constituent state units to ascertain if they had advisory councils appointed by their medical associations brought replies from thirty and revealed that twenty-eight of those did have an advisory council. One of our goals for this year is an advisory council or counselor for each of our county and state Auxiliaries. Where does your own Auxiliary stand with relation to this goal? It is hoped that each state president reporting at New Orleans will be able to say that not only her state Auxiliary but that each of its constituent county units has an advisory council or counselor.

The president of an Auxiliary in one of the sparsely settled western states, where great distances and mountainous country make frequent meetings impossible, wrote that she had received much inspirational material from the various national chairmen this year, but that as yet, her Auxiliary is only a social organization, whose primary purpose is to stimulate its members to attend annual meetings so that the attendance of the doctors themselves may be increased. This is a laudable goal. This Auxiliary is already a "reserve force" for its medical society. When the doctors in that state medical society find out how those in the neighboring state societies are using their Auxiliaries to promote understanding between the medical profession and the public, perhaps they, too, may desire to use their "reserve force" for further service, and the Auxiliary in the meantime may be reviewing the work of other Auxiliaries as reported in the state Journals, the Bulletin, the Minutes and Reports of the Convention, and preparing itself for service when called upon.

Some of the newly-organized Auxiliaries are attempting nothing more than to bring about unity and solidarity within the profession by means of social contacts between the families of doctors. My observation on my visits to Auxiliaries during this year leads me to believe that this function of the Auxiliary should not be underestimated. The medical societies are apparently, more and more, recognizing the forces both within and without the profession that are working counter to the best interests of the profession and the public and are feeling the need of a *unifying* force such as an Auxiliary may be when given sufficient encouragement and cooperation, and guidance by its medical society.

The growing interest in the educational and public relations programs of the Auxiliaries this year has been most gratifying. That many state medical societies have prepared educational programs for their Auxiliaries and have endorsed the National Auxiliary study envelopes for use in developing these programs is satisfying. In an increasing number of county Auxiliaries a few women are being discovered who are vitally interested in the educational programs and who are a real force in interpreting the ideals and work of the medical profession to other women's groups in which they work by influencing these groups in the choice of approved literature and speakers to be used on their health programs. One of our goals this year is to discover such women, to urge them to represent our groups in other women's organizations by accepting positions of leadership therein, and to back them up by our loyal support. Are there such women in your group working, or capable of working under supervision of your advisory council in other women's organizations?

The state Auxiliaries have made much progress this year in securing chairmen corresponding to the national chairmen. Our organizations cannot function properly until county Auxiliaries also have such chairmen who will receive program suggestions and materials from the state chairmen and who will report to the state chairmen on the progress of the county work. The function of the National Auxiliary is to stimulate interest in types of approved work possible to be done and to serve as a clearing house for information on the kinds of work being done successfully by the various Auxiliaries. It is obvious that little interest can be stimulated if there are not county and state chairmen corresponding to the national. How near to this goal is your Auxiliary?

Where do you stand with relation to your Hygeia goal? We have repeatedly said that Auxiliaries are organized to carry on those projects advised or approved by the medical associations. The House of Delegates of the American Medical Association in the Convention at Philadelphia last spring asked that we "recognize as one of our chief activities the promotion and distribution of this publication through parent-teacher associations, boards of education and similar bodies interested in education."

Do all of us realize that the American Medical Association is publishing Hygeia for the layman to meet his insistent demand for information concerning the functions and care of the human body, and

that if this demand is not satisfied by *authentic* information that he is more likely than not "to go floundering away from scientific medicine?" If any of you are doubtful as to the helpfulness of Hygeia for teachers, mothers, nurses or doctors write to Mrs. Rogers N. Herbert, 1509 Stratton Avenue, Nashville, Tennessee, for a folder of "Hygeia talks," which will probably convince you. If you are not a reader of Hygeia write, The Circulation Manager, 535 North Dearborn Street, Chicago, Illinois, for a sample copy, read it and let it convince you of its value.

No woman who is promoting the distribution of Hygeia through schools or homes or other educational groups should consider herself a magazine solicitor, but instead she should feel that she is an important factor in a health education project, devised and promoted by the American Medical Association, for the good of both the profession and the public.

A most interesting and inspiring development in Auxiliary work that was revealed by some of the states reporting at the mid-year board meeting in Chicago is that several of the state Auxiliaries now have a portion of the time of an assistant-executive secretary appointed by their respective medical societies. Minnesota, Illinois and Wisconsin reported such co-operation. Is that kind of relationship between a State Medical Association and its Auxiliary not a goal for which to hope!

And now as I write, there comes through the mail the fulfillment of one of the Kentucky Auxiliary goals set at their annual meeting at Lexington in September which I attended—the first issue of their new "Quarterly," the first bulletin, I believe, to be undertaken by a state Auxiliary! Congratulations, Kentucky!

The National Auxiliary does not presume to dictate, it desires only to collect and exchange plans to advise and to stimulate state presidents and their chairmen. The annual conventions and mid-year board meetings are our greatest factors in stimulating interest. It is in these meetings that the values of the Auxiliary become apparent; it is here where by reports, by conferences and discussions, we measure our progress, evaluate our methods and discover our mistakes; it is here that we discover our strength and our weakness, it is here that we set our goals.

We believe that the national mid-year board meetings and conventions are so important in the life of the Auxiliary that every board member should consider it an obligation when reasonably feasible to attend. We are suggesting that each state Auxiliary set this new goal for itself at its next annual meeting if possible; that it provide sufficient means to insure its state president's attendance at the mid-year board meeting in Chicago, and at the annual Convention in the spring. We believe that every state chairman should make an honest effort to attend the national convention.

Mrs. Joseph Hume of New Orleans is the chairman of the next convention which is to be held next May 9-13 in that interesting old city of the South—New Orleans. Our own President-Elect, Mrs. Walter Jackson Freeman, who so skillfully guided the convention in Philadelphia, is also a member of the New Orleans Convention Committee.

There we shall find both pleasure and inspiration. May I hope to meet you there, one and all! May we have the satisfaction of reporting that we have reached all goals set for the current year! There are yet three more working months in which to accomplish them.

And won't you all be considering the goals we should set for next year?

Faithfully yours,
(Mrs. Arthur B.) ANNA F. MCGLOTHLAN.

FROM THE STATE PRESIDENT

To the Doctor's Wife:

On behalf of the Woman's Auxiliary to the State Medical Society, I desire to express our grateful appreciation of the privilege of a page devoted to Auxiliary affairs. Our state publicity chairman will at all times welcome items of interest for this page.

To those wives of medical men who, as yet, are not affiliated or whose county is not organized, may we not tell you of some of the advantages of an Auxiliary? The Organization Chairman and Executive Secretary will be glad to have you consult them at any time.

Subtle and insidious propaganda has been directed toward organized medicine due to the isms, cults and pseudo scientists. It deceives even the well-intentioned unless they give it careful thought. The American Medical Association with its component units are ever alert and fighting for truth in the practice of medicine. Medical men are falsely accused of having selfish motives by individuals who are trying to confuse the unsuspecting public. Why should we wives stand aloof when our husbands are fighting for the truth? As we begin to study and understand the spirit of organized medicine we become eager to enlist and defend the truth.

Self health education is one of the great objects of the Auxiliary. This is necessary in order that we may spread true health information in our daily contacts with the public in parent-teacher associations and other lay organizations. A program in no way obligatory, but one that would act as a general guide for your health studies has been outlined and may be obtained from the State Program Chairman. Each unit may decide what its program shall be. However, a study of the Code of Medical Ethics which embraces the high ideals and lofty motives of our husbands' profession is strongly recommended and may be made an interesting part of the program. Our chairman suggests a paragraph of the code be read and discussed at each meeting with any other program you may plan.

The promotion of Hygeia is a very fine way of doing health education work. Since this magazine is sponsored by the American Medical Association and is authoritative information, intended for lay

people, it should have a wide distribution. Write to our State Hygeia Chairman for more detailed information.

Let us then come forward and give our wholehearted support to our Auxiliaries. In so doing we promote friendliness among doctors' families, guide health activities, promote self health education and engage in any worthy philanthropic activities we may wish to undertake.

It would be most gratifying to have all of the counties of the State of Wisconsin represented in the roll call at the annual meeting in September in Milwaukee. As President of the Woman's Auxiliary to the State Medical Society of Wisconsin, I will be most happy to hear from you, and be of assistance to you.

Sincerely yours,
(Mrs. Henry J.) FRANCIS GRAMLING,
State President.

* * *

The following committees were appointed by Mrs. James C. Sargent, president of the Woman's Auxiliary to The Medical Society of Milwaukee County, at the last meeting of the Auxiliary on January 8th, and same were confirmed by the board of directors. The committees are as follows:

Hygeia Committee: Mrs. Harvey E. Webb, Chairman; Mrs. Bernard Krueger, Mrs. Walter Stranberg, Mrs. Elmer Gramling, Mrs. Robert McDonald, Mrs. M. W. Sherwood, Mrs. Robert Brunkhorst, Mrs. A. L. Bork, Mrs. Claude Beebe.

Telephone Committee: Mrs. R. P. Sproule, Chairman; Mrs. R. P. Schowalter, Mrs. P. L. Callan, Mrs. Ray Dalton, Mrs. J. E. Habbe, Mrs. G. I. Hogue, Mrs. J. M. King, Mrs. J. Gurney Taylor, Mrs. F. X. McCormick.

Program Committee: Mrs. Stanley J. Seeger, Chairman; Mrs. Henry J. Gramling, Mrs. S. M. Markson.

Public Relations: Mrs. Rock Sleyster, Chairman; Mrs. C. H. Davis, Mrs. Jas. Hackett, Mrs. Francis Murphy, Mrs. F. R. Janney, Mrs. Karl Schlaepfer, Mrs. A. J. Patek, Mrs. Chas. Stoddard, Mrs. E. F. Peterson.

Publicity Committee: Mrs. Carl Eberbach, Chairman; Mrs. Robert W. Blumenthal, Mrs. Lee J. Foley.

Membership Committee: Mrs. Joseph Lettenberger, Chairman; Mrs. Geo. W. Neilson, Mrs. P. M. Currer, Mrs. Norbert Enzer, Mrs. P. S. Epperson, Mrs. A. W. Gray, Mrs. W. F. Grotjan, Mrs. Wm. Jermain, Mrs. J. J. Adamkiewicz.

Social Committee: Mrs. E. L. Tharinger, Chairman; Mrs. Charles Fidler, Mrs. W. H. Washburn, Mrs. A. R. F. Grob, Mrs. Millard Tufts.

Convention Committee: Mrs. L. M. Warfield, Chairman; Mrs. H. J. Gramling, Mrs. E. L. Tharinger.

NEWS ITEMS AND PERSONALS

Dr. C. A. Dawson, River Falls, commander of the American Legion, department of Wisconsin, addressed a meeting of the Forty et Eight Society held in Madison, January 9, 10 and 11. Dr. Dawson spoke on "The Hazard of the Handshake."

Dr. Otho A. Fiedler, Sheboygan, President of the State Medical Society, was one of the principal speakers at the Monday afternoon session. Dr. Fiedler discussed the need of local hospitalization for the care of disabled World War veterans at the expense of the federal government, rather than the construction of additional federal hospitals.

The executive committee of the Legion named Dr. E. J. Barrett of Sheboygan as a member of a committee to investigate the medical treatment of veterans and to report its findings at the La Crosse convention to be held in August.

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Dr. G. M. Hoffman, city health commissioner of Manitowoc, addressed the members of the Manitowoc and Two Rivers Public Health Nurses club at a recent meeting.

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Dr. Ira F. Thompson of Syracuse, New York, was named as health commissioner of Racine by the Board of Health to succeed Dr. W. W. Bauer, who resigned January 1st to become assistant director of the bureau of health and public instruction of the American Medical Association. At Syracuse, Dr. Thompson was in charge of the Milbank Fund.

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Dr. B. P. Tillotson, formerly of Chicago, is now associated with Dr. D. H. Jeffers of Lake Geneva. Dr. Tillotson served as resident physician at both St. Luke's and Wesley Memorial hospitals in Chicago.

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Dr. August Sauthoff, assistant superintendent of the State Hospital for the Insane at Mendota, will

INCOME TAX DATA

Because final action has not been taken relative to changes in the tax laws, both state and federal, and because income tax returns need not be filed before March 15th, physicians are urged to withhold making returns until Feb. 15th. By that time the usual compilation of the State Society, listing deductions and rates of depreciation which are allowed, will be sent direct to each member by mail.

sail on February 23rd for a Mediterranean cruise. He expects to be gone about two months.

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Health examinations of all high school students in Appleton were made in January under the supervision of the Outagamie County Medical Society and the Appleton Woman's Club. Nearly 1,000 students were examined.

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Dr. C. A. Harper, State Health Officer, Madison, addressed a meeting of the Fond du Lac Kiwanis Club in January.

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Dr. O. N. Mortensen of Wisconsin Rapids is receiving medical treatment at the Mayo Clinic, Rochester.

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Dr. G. J. Hathaway, Superior, was elected chief-of-staff of St. Mary's hospital. Dr. H. A. Sincock was elected vice-president and Dr. E. A. Meyers was named secretary.

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Dr. Nathan E. Bear, a graduate of Northwestern University Medical School in 1931, in January became associated with his father, Dr. W. G. Bear of Monroe.

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Dr. R. S. Elliott, formerly of Milwaukee, has moved to Waupaca where he is occupying the office of the late Dr. F. E. Chandler.

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Dr. Clifford Y. Wiswell, a graduate of the University of Wisconsin Medical School and formerly of Elkhorn, has purchased the practice of the late Dr. E. J. Fucik of Williams Bay.

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Rejection of the offered contract of the Dane County Medical Society to care for the county's indigent sick for $20,000 annually was voted by the welfare committee of the Dane County Board.

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Announcement of the association of Dr. H. W. Howe with the Racine Clinic was made by the members of the Clinic on January 4th. Dr. Howe, who spent several years in Paris, Vienna and Berlin, will specialize in diseases of the eye, ear, nose, and throat.

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A medical bag containing equipment valued at $100 was stolen from the car belonging to Dr. George H. Stevens of Wausau. Another bag containing surgical instruments was unmolested.

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Dr. F. H. Ferguson, formerly of Waupun, moved to Elroy the latter part of December to establish a practice.

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Visitors at the offices of the State Medical Society in January included the following: Dr. Otho A. Fiedler, Sheboygan; Dr. J. Gurney Taylor, Milwaukee, Dr. Frank L. Rector, Evanston, field representative for the American Society for the Control of Cancer, Dr. J. J. McCarthy of Sun Prairie and Dr. E. E. A. Dunn of Platteville.

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The home of Dr. R. J. Hudson of Prairie du Sac was damaged by fire to the extent of $2,000 which occurred early in the morning of January 5th.

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Dr. William H. McGuire, Janesville, was elected president of Mercy hospital staff at a meeting on January 7th. Other officers are: Dr. V. W. Koch, vice-president; Dr. Harry D. Lapp, secretary and treasurer; Drs. McGuire, W. T. Clark, Wayne A. Munn, A. H. Pember, Theodore Klein and E. C. Hartman, executive board. Following dinner, a paper on "Diphtheria" was read by Dr. Fred B. Welch city health officer.

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Dr. Carl S. Williamson of Green Bay has been promoted to the rank of Captain in the Medical Reserve Corps, according to a War Department announcement on January 11th.

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The license of Dr. Robert B. Smiley of Stevens Point has been revoked, according to word received from Dr. Robert E. Flynn, secretary of the State Board of Medical Examiners. Dr. Smiley was convicted on December 10, 1931, in circuit court at Portage, Judge Byron B. Parks presiding, for violation of Section 351.22 and was fined $500 and costs. After reviewing his credentials and transcript of the court record, the Board revoked his license. Dr. Smiley was granted a license by examination by the Board on July 8, 1902.

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Dr. Wayne A. Munn, Janesville, was appointed supervisor from the seventh ward of the city of Janesville, to fill the vacancy caused by the death of the former incumbent.

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Through the cooperation of Station WHBL, Sheboygan, health talks are now being made by Dr. G. J. Hildebrand of Sheboygan. This program is broadcasted every Tuesday afternoon under the auspices of the local health department.

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Dr. W. W. Kelly, Green Bay, was appointed a member of the University Board of Visitors by Governor P. F. La Follette.

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Dr. Charlotte Calvert of the bureau of maternity and child welfare of the State Board of Health, addressed a meeting of the League of Women Voters on January 18th, at Madison. Dr. Calvert spoke on legislation regarding federal appropriation for infancy and maternal state programs.

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Dr. Mary E. Pogue, who many years ago conducted a sanitarium for feeble-minded children at Lake Geneva, died on January 3rd in a Chicago hospital. More recently, Dr. Pogue conducted a similar institution at Wheaton, Illinois.

One Day Review of Oxygen Therapy Progress Offered for Twenty at University of Wisconsin

On Tuesday, February 23, 1932, the University of Wisconsin will offer a one day demonstration and discussion of the use of oxygen and carbon dioxide as a resuscitative and therapeutic procedure.

Physicians of the State Society who wish to register for this course will please do so through Doctor R. C. Buerki, Superintendent of the Wisconsin General Hospital. Registration will be limited to twenty. There will be no charge for this course, except for the cost of the sandwiches and coffee served at noon.

The following tentative program for the day has been outlined:

9:30 to 10:30—Principles of Oxygen Therapy; Causes of Need from Physiologic Standpoint; Signs of Oxygen Want; Guides to Knowledge of Result from Therapy in Acute Cases; Oxygen Therapy in Chronic Cases—Drs. Meek and Waters.

10:45 to 12:00—Technique of Tents and Chambers Illustrated, Advantages Discussed; Mask Administration, Nasal and Oral, for Resuscitation in Acute and Chronic Cases; Use of Soda Lime.

Pharyngeal Insufflation; Apparatus, Flow Meters, Moisture, Etc.; Technique of Use of Catheters; Anatomical Sagittal Section of Pharynx; Insertion of Catheters in Pharynx—Dr. Waters and Staff.

1:30 to 2:30—Physiologic Effects of Oxygen Want—Laboratory Demonstrations—Dr. Seevers.

3:00 Discussion Clinical Aspects of Oxygen Therapy and Ward Demonstrations—Dr. Middleton.

Dr. M. H. Fuller of Green Bay gave a lecture on deafness before a meeting of the Sisters and nurses of St. Mary's Hospital, Green Bay, January 14th.

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Twenty-eight physicians in the state have registered for the course in urology for general practitioners. Under the direction of the Department of Urology of the University of Wisconsin a series of one-day clinics are being given during the winter months. Following are the names:

Drs. J. F. Mauermann, Monroe; W. H. Remer, Chaseburg; H. O. Caswell, Fort Atkinson; A. J. Wiesender, Berlin; Hugh Caldwell, Columbus; F. M. Frenchette, Janesville; C. U. Senn, Ripon; H. A. Raube, Beloit; Raymond Mundt, Oconomowoc; George N. Pratt, Neenah; A. L. Schemmer, Colby; B. W. Shaw, Waunakee; L. J. Unterholzner, Blanchardville; C. F. Dull, Richland Center; Frank Griswold, Mazomanie; George W. Griswold, Alma Center; H. J. Irwin, Baraboo; C. E. Myers, North Freedom; Harry A. Keenan, Stoughton; A. T. Smedal, Madison; P. M. Kauth, West Bend; Paul L. Eisele, Ripon; W. M. Wochos, Kewaunee; R. H. Ludden, Viroqua; and the following from Milwaukee, A. W. Loeber, N. F. Dettmann, Nathan Goldberg, S. M. Turkeltaub.

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MILWAUKEE

Diseases of the Heart, the second in a series of postgraduate courses sponsored by the educational committee of The Medical Society of Milwaukee County, opened on Monday evening, January 4th, at the Milwaukee Academy of Medicine, with Dr. Don C. Sutton, associate professor of medicine of the University of Illinois College of Medicine, as the principal speaker.

The instructors for this course are: Drs. Louis F. Jermain, L. F. Ruschhaupt, A. J. Patek, Louis M. Warfield, Francis D. Murphy, F. W. Madison.

The following Society members have enrolled for this course:

Drs. Donald C. Ausman, A. L. Bork, Dirk Bruins, P. L. Callan, E. H. Darling, Albert Popp, Ralph T. Rank, C. C. Reinke, R. C. Schodron, Bernard Schlossmann, G. J. Schweitzer, J. J. McGovern, T. L. Johnston, J. A. Murphy, W. V. Nelson, Geo. M. O'Brien, J. B. Ozonoff, M. M. Spitz, F. J. Stirn, Millard Tufts, L. A. VanElls, R. P. Wiesen, Jacob Fine, L. A. Bernhard, Edward Jackson, C. D. Jurss, F. J. Korthals, Bernard Krueger, Benj. Lieberman, J. F. Blair, J. F. Gulas, E. P. Evans, J. W. Fons, P. G. Frey, Edwin B. Gute, H. T. Hansen, C. J. Becker, L. M. Brooks, M. B. Byrnes, W. S. Darling, N. F. Dettmann, A. A. Pleyte, H. Rasmussen, E. H. Rogers, Elias Schlomovitz, H. F. Scholz, W. F. Weingart, H. B. Miner, O. A. Sander, G. W. Neilson, P. J. Niland, W. P. O'Malley, E. F. Peterson, L. P. Stamm, A. L. Suhr, S. M. Turkeltaub, P. C. Wagner, J. C. Zuercher, J. G. Curtin, H. L. Herschensohn, Frances Johnson, L. W. Juergens, G. Alan Kriz, A. F. Kusterman, S. Spilberg, W. L. Stranberg, P. J. Eisenberg, L. A. Eisenberg, M. Fernan-Nunez, Urban E. Gebhard, E. T. Harrington, Harry Beckman.

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Dr. J. W. Smith left Milwaukee during the holidays for New York, Vienna, and Paris, where he expects to be absent for one year during which time he expects to study dermatology.

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A resolution endorsing the employment of doctors for city ambulances was unanimously adopted at a meeting of the Pulaski Council on December 24th. A committee was appointed to draw the resolution and present it to the common council.

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Dr. and Mrs. Curtis Brown returned the 9th of January to their Milwaukee residence from their country home in Fox Point.

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Dr. Alexander Schlapik, formerly of Milwaukee, was elected President of the Kenosha County Medical Society on January the 6th.

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Dr. Arthur W. Rogers, Oconomowoc, was re-elected chairman of the council of the State Medical Society at a meeting of the council in Milwaukee on January 9th. Dr. Rock Sleyster of Wauwatosa was re-elected treasurer, and Mr. J. G. Crownhart, secretary of the State Medical Society, Madison, was re-elected secretary.

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Drs. Olin West, Morris Fishbein, and Mr. Will Braun, officials of the American Medical Association, spent Saturday, January 9th, in Milwaukee to inspect the Auditorium and hotel facilities in connection with the invitation which the Association has received to hold its 1933 convention in Milwaukee.

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At a meeting of the Fourth and Fifth Districts Nurses Association, held at the South View Hospital on January 12th, Dr. W. W. Bauer, assistant director of the bureau of public health and instruction of the American Medical Association, spoke on "Industrial Nurses and Their Relation to the Health Program."

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Dr. F. W. Seegers on January 10th, announced the engagement of his daughter, Verna, to Mr. Edward G. Gerbic of Oshkosh, Wisconsin.

Dr. and Mrs. J. J. Seelman, during the holidays announced the engagement of their daughter, Eleanor to Stuart H. Breitwish, son of Mr. and Mrs. A. J. Breitwish.

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Dr. and Mrs. J. F. Zivnuska, on December 31st, announced the engagement of their daughter, Gertrude, to E. Walter Rickmeyer of Chicago, son of Mr. and Mrs. Carl Rickmeyer of Gerstungen, Germany.

Dr. A. C. Sidler left on December 28th for a round-the-world tour. He expects to return to Milwaukee in June, 1932.

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Dr. A. R. F. Grob, with a party of friends, motored to Canada during the holidays.

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Much interest is being displayed by proprietors and owners of Milwaukee eating houses in the plan sponsored by the health council of The Medical Society of Milwaukee County, urging the physical examination (for contagious or infectious disease) of all food handlers in Milwaukee. Every day the Society is receiving calls from restaurant men offering their cooperation and voicing their approval of the plan. Definite plans will be forthcoming soon, according to members of the health council, of which Dr. Ralph P. Sproule is chairman, and Drs. R. W. Blumenthal, H. J. Gramling, Millard Tufts, and W. F. Grotjan, are members.

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Dr. W. H. Powers, representing the Speakers' Bureau of The Medical Society of Milwaukee County, addressed the Parent–Teacher Association of the Wilson School, Wauwatosa, on January 11th, on "Character Formation in the Child."

Dr. Millard Tufts, also a member of the Speakers' Bureau, spoke at the Galena Street Methodist Church on Sunday, January 10th, on the subject of "Are You Overweight?"

At a meeting of the Milwaukee Dietetics Association, held in the Children's Hospital Convalescent Home on January 6th, the speaker was Dr. M. G. Peterman.

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At a meeting of the hospital staff of St. Mary's on January 6th, Dr. Arthur R. Rheineck was elected President; Dr. Charles Fidler, Vice-President, and Dr. Robert Bach, Secretary–Treasurer.

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On January 6th, Dr. F. A. Stratton addressed the Woman's Home Service League on "The Thyroid Problem in the Great Lakes District."

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Dr. Charlotte Calvert of the state board of health spoke on the radio forum program of the Wisconsin League of Women Voters, over the Milwaukee Journal Station, WTMJ, on Tuesday, January 12th. Her subject was "Safeguarding the Health of Mothers and Babies."

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Dr. M. J. Sharples was fatally injured and Dr. Frank Schubert very seriously injured in an automobile accident on the afternoon of January 6th. They were returning from a medical meeting in Chicago when the accident occurred.

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The colleagues of Dr. Roland S. Cron are indeed happy to learn that he has made a splendid comeback. He and Mrs. Cron left Milwaukee on January 18th for Palm Springs, California, where they will spend the remainder of the winter, Dr. Cron's attending physicians declaring that he needs only a rest to perfect a complete recovery.

Dr. and Mrs. E. L. Baum left on January 12th for their winter home in Naples, Florida.

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Dr. Walter G. Darling was re-elected a member of the Milwaukee Council of Boy Scouts, according to an announcement from the executive board.

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At the annual meeting of the Milwaukee League of Nursing Education, held Friday, January 15th, at Mt. Sinai Hospital, Miss Blanche Graves, superintendent of nurses at that institution, was elected president. Sister St. Emily, superintendent of nurses at Misericordia Hospital, and Miss Clara Bumiller, surgical supervisor of Mt. Sinai Hospital, were chosen directors.

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The general health of Milwaukee school children was declared to be excellent by Dr. George P. Barth, school physician of the Milwaukee Health Department, in his report of January the 9th. A summary of the mid-year physical examinations given to 80,000 school children disclosed that only 1,498 had ailments, the great majority of which were minor.

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Edward G. Quick, son of Dr. and Mrs. Edward W. Quick, died Wednesday, January the 13th, at Columbia Hospital, of pneumonia. Besides his parents Edward is survived by his sister, Louise, and his grandmother, Mrs. Augusta Hall. He was sixteen years of age.

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The following health talks, sponsored by the State Board of Health, and delivered by Mr. Theodore Wiprud, executive secretary of The Medical Society of Milwaukee County, will be broadcast over the Milwaukee Journal Station, WTMJ, during the month of February:

February 5, "Anemia"; February 12, "Whooping Cough"; February 19, "Climate and Health"; February 6, "When You Have a Goiter".

All of these broadcasts will be presented from 3:45 to 4:00 P. M.

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At a meeting of all chairmen of committees in The Medical Society of Milwaukee County, held in the Mariner Tower on January the 11th, plans for the ensuing year were discussed. Copies of suggested plans for each committee were passed out to all present and the plans discussed by each chairman.

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The Physicians' Service Bureau membership committee met in the Mariner Tower on January 12th to discuss ways and means of stimulating interest in Bureau service, and of enlarging the membership. It was agreed that regular monthly meetings of this committee should be held the second Tuesday of each month.

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The health council held a meeting at the University Club on January 12th, the purpose of which

was to discuss the plan for the examination of food handlers. An outline of a plan, prepared by the secretary, was submitted and was approved by the council.

The council agreed to issue to restaurants, fully complying, certificates showing that all of their employees had been examined. It was suggested that cards be issued to employees stating their physical condition to be satisfactory. Detailed plans for these examinations are now being made.

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At a meeting of the program committee, held in the Mariner Tower on January 13th, tentative plans for the ensuing year were outlined. A most interesting and varied program for 1932 has been planned by this committee.

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The name of Dr. E. L. Dallwig, suggested by Dr. Paul M. Currer, president of The Medical Society of Milwaukee County, as a member of the advisory board of the Johnston Emergency Hospital, to succeed Dr. Currer, was approved by the board of directors of the Society at their meeting held on January 15th, in the Mariner Tower. Dr. J. P. Koehler, Health Commissioner, has just announced the appointment.

The request of the Woman's Auxiliary to The Medical Society of Milwaukee County, that the board appoint an advisory committee to which the Auxiliary might refer its problems, was granted. The board appointed the following to that position: Drs. R. W. Blumenthal, S. J. Seeger, and Ralph P. Sproule.

The board agreed that a time should be set for regular monthly meetings, and the fourth Tuesday of each month was chosen, the hour to be 5 P. M.

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Dr. Francis D. Murphy, appearing for the Speakers' Bureau of the Society, spoke before the Exchange Club at the Hotel Pfister on January 21st, at a noonday lunch meeting. His subject was "What You Should Know About High Blood Pressure."

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Dr. J. L. Yates returned on January 19th from a trip to Baltimore, Maryland.

BIRTHS

A son, Peter Maurice, to Dr. and Mrs. M. E. Ross of Brodhead on January 6th, at Beloit Municipal Hospital.

MARRIAGES

Dr. Robert Irving Hiller, Milwaukee, to Miss Ruth Krome, Milwaukee, Sunday, January 3, at the home of Mr. and Mrs. Max Krome, Milwaukee.

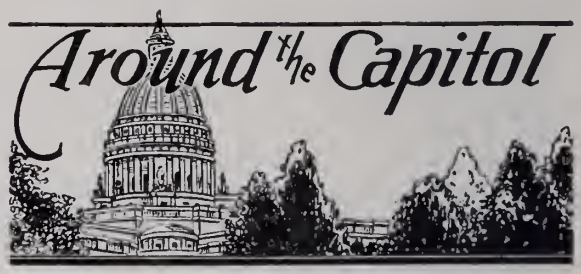
SOCIETY RECORDS

New Members

A. T. Smedal, 110 E. Main St., Madison.
H. L. Greene, 1 South Pinckney St., Madison
H. S. Schumacher, 2742 N. Teutonia Ave., Milwaukee.
J. Martin Sansby, 2105 N. Prospect Ave., Milwaukee.
Benjamin E. Urdan, 425 E. Wisconsin Ave., Milwaukee.
M. M. Hipke, 425 E. Wisconsin Ave., Milwaukee.
Albert Bardes, 3306 Highland Ave., Milwaukee.
O. A. Sander, 531 W. Wisconsin Ave., Milwaukee.
Otto A. Backus, State Bank Bldg., Nekoosa.
Frank A. Boeckmann, Marshfield Clinic, Marshfield.
A. L. Herron, 1012 N. Third St., Milwaukee.
F. G. Bachhuber, Mayville.
I. H. Lavine, Melrose.
Alvin J. Dupont, Pulaski.

Changes in Address

Francis N. Nimz, Iron Ridge to Henke Clinic, La Crosse.



According to Dr. Harry L. Russell, former dean of the Wisconsin College of Agriculture, now head of the Wisconsin Alumnus Research association which controls the Steenbock patent, it will only be a short time before licenses will be issued to commercially handle vitamized certified milk produced under the Steenbock process of feeding irradiated yeast to cows. He explained that it will be a non-exclusive license which will be granted to any dairy which complies with the requirements, including approval of the local medical association where dairy proposes to sell the vitamized certified milk.

Four to eight times as much vitamin D, which is concentrated sunshine, was carried by the milk produced by feeding irradiated yeast to the cows as in normal milk, according to experiments made at the Wisconsin College of Agriculture two years ago.

* * *

Among Wisconsin children less than five years of age, boys have considerably less change than girls of surviving to reach school age, according to the bureau of vital statistics, state board of health.

Analysis of the 1930 mortality of children under the age of five reveals that of the state total of 4,038 deaths more than 57 per cent were of boys, while among the living members of this age group it is estimated that the boys form less than 52 per cent of the whole.

Study of 1930 deaths in this group according to death causes reveals that in only one important classification, that of whooping cough, were thero more deaths among girls than boys. Chief among the

single ailments that menace the lives of children under five years was pneumonia, which took toll of 346 boys and 256 girls in the state in 1930, and second in importance was diarrhea and enteritis, which cost the lives of 198 boys and 172 girls. Deaths from violent and accidental causes carried out the predominance, claiming 94 boys and 62 girls, the survey showed.

* * *

Infantile paralysis was more severe in Wisconsin during 1931 than in any previous year in the public health annals of the state, according to Dr. H. M. Guilford, state epidemiologist.

"This baffling disease was added to the state list of reportable ailments in 1910, following two years of high prevalence," Dr. Guilford said, "and for the 21 years during which it has been reportable, an average of 125 cases annually has marked the degree of prevalence."

Although Wisconsin's 555 cases for the first nine months of 1931 exceeded the 12 months' total for any year since 1910, the percentage of deaths in 1931 was lower than any on record.

» » » CORRESPONDENCE « « «

BASIC SCIENCE BOARD MEETING

STATE BOARD OF EXAMINERS IN THE BASIC SCIENCES

(Anatomy, Physiology, Pathology and Diagnosis)

Madison, Wisconsin, January 8th, 1932.

Wisconsin Medical Journal,
Madison, Wis.
Gentlemen:

The next examinations by the Wisconsin State Board of Examiners in the Basic Sciences will be held on March 19th, 1932, at the Hotel Loraine, Madison, Wis.

Application for examination to be made to Robert N. Bauer, secretary, 3414 W. Wisconsin Ave., Milwaukee, Wis.

Very truly yours,
ROBERT N. BAUER,
Secretary, Basic Science Board,
3414 W. Wisconsin Ave.
Milwaukee, Wis.

FROM PRAIRIE DU CHIEN

Prairie du Chien, Wis.,
January 23, 1932.

Mr. J. G. Crownhart,
Secretary, State Medical Society,
Madison, Wisconsin.
Dear Sir:

The members of Fort Crawford Chapter, Daughters of the American Revolution, are deeply appreciative of the kindness evidenced during the past year by the State Medical Society of Wisconsin to the preservation of a portion of the Fort Crawford military reservation at this place. We are very proud of the handsome Beaumont Memorial boulder and tablet, which adds so much to the interest and significance of the spot. And now we wish to express our gratitude for the generous check presented to us yesterday by Dr. Armstrong. The money shall be used in the preservation and care of the Fort property, and is a very welcome and helpful addition to our small bank account.

Very truly yours,
(Signed) MRS. J. S. EARLL,
Secretary Fort Crawford Chapter, D. A. R.

PREFERRED CLAIMS

January 13, 1932.

Mr. J. G. Crownhart,
State Medical Society,
119 East Washington Avenue,
Madison, Wisconsin.
Dear Mr. Crownhart:

You asked exactly what is the legal status of the physician's account for services rendered a deceased patient during the last illness, and to whether such claim is preferred ahead of the undertaker, hospital, nurse, and/or attorney.

Section 313.16 of the Wisconsin Statutes provides that when: "it shall appear that the executor or administrator has in his possession sufficient to pay all the debts, he shall pay the same in full within the time limited for that purpose. If the assets received by the executor or administrator, and which can be appropriated to the payment of debts, shall not be sufficient he shall, after paying necessary expenses of administration, pay the debts against the estate in the following order:

"(a) The necessary funeral expenses;
"(b) The expenses of the last sickness;
"(c) Debts having a preference under the laws of the United States."

The law further provides that if there shall not be assets enough to pay all the debts of any one class, each creditor shall be paid a dividend in proportion to his claim; and no creditor of any one class shall receive any payment until all of these of the preceding class shall be fully paid.

Expenses of administration, which include legal services, are first to be paid. Then the funeral expenses, and then the expense of last sickness. If the amount remaining after the expenses of administration and funeral expenses is not sufficient to meet the entire expense of the last sickness, the amounts of these claims must be prorated.

Very truly yours,
FRED L. HOLMES, *Counsel for State Medical Society.*

Socialized Medicine*

By C. A. HARPER, M. D.
State Health Officer, Madison

I am invited to discuss the subject of state or socialized medicine and its probable approach in the field of general medicine in this country. The terms "state and socialized medicine" may be used as synonymous as the line of demarcation is not readily or easily drawn. Neither term is well defined or well understood as to its far-reaching application. Suffice to say that socialization of medicine has had no general invitation by the medical profession to cross the threshold of organized medicine; its knocks have been unheeded and unwelcomed. It has met with almost universal opposition by the physicians individually as well as by medical groups. In spite of this opposition twenty-three countries have some form of socialized medicine and seventeen other countries are giving it serious consideration. It now has invaded North America so that our neighbors, British Columbia and Alberta, are succumbing. In the United States, newspapers and magazine articles are numerous discussing the program and its possibilities.

Organized medicine can no longer remain indifferent to the dangers confronting it. If the tide cannot be stemmed by united efforts it certainly can be guided along reasonably acceptable channels with the hope that the medical profession will still retain its dignity, its scientific individuality, its competitive character and the vitally important relationship now existing between doctor and patient. Indifference will not solve the problem. If the challenge is met and met squarely the problem should be solved in a manner satisfactory to organized medicine; holding intact the traditions of the medical profession, and destroy the ammunition of the agitators for general socialized medicine.

One of the primary functions of government is to consider the health and welfare of its citizens. It is not strange, therefore, that with the evolution of government in many of its phases medicine should become involved and socialized medicine be one of the Utopias to be tried out in this change. That there is developed general agitation towards socialized medicine is common knowledge to us all. Certain aspects of socialized medicine have been with us for a long time. Certain elements of our citizenship scattered throughout the country have become familiarized with its possibility and in many instances considering its probabilities as a whole.

During the nineteen months the United States was engaged in the World War some four million became acquainted with the application of governmental medicine, many of whom are having medical care provided at the present time. Again certain life insurance companies are entering the field of preventive as well as partially curative medicine. Such procedure has been found to give about 100% returns to these various companies on their investment. We have life extension institutions, health institutes, etc., many of which are owned and operated by laymen socializing the doctors to give the necessary medical care and advice. Many industries have found it profitable and efficient to engage well qualified physicians to be in charge of the health and welfare of employees, various fraternal societies have a lodge physician.

The care of the county indigents has frequently been assigned to the lowest bidder or these paupers have been pauperizing the medical profession to give gratuitously the necessary medical care. Over-zealous and sometimes misdirected social workers in various communities are pauperizing many of its citizens. Departments of health, of necessity, occasionally come in for criticism in this respect. So from many avenues we see the ear marks of socialized medicine, and rub elbows with some phase of the problem almost daily. Many physicians in rural communities are seeing their patients going to the medical centers for treatment and hospital

* Address presented before the several component county societies during 1931 when President of the State Medical Society of Wisconsin.

care with but scanty consideration in many instances for the city man. To some of these rural men socialized medicine, as the wolf at the door continues to howl, is not without its charm. It is probably not unnatural that these conditions have come up on us. The physician has been so much concerned about the welfare of his patients that he has given little consideration concerning the future of scientific medicine. The time has come, however, for an enlightened profession to set standards of sound public policy by being alert to the socialistic dangers to medicine and by uniting give aggressive opposition to its many undesirable phases and intelligent guidance to others.

The London Times last August commenting upon panel practice in England states, "His (the physician's) freedom to treat his patients according to the dictates of his knowledge and experience is a doctor's most valued and most valuable possession. To compel him to justify or explain the exercise of that freedom is to limit it in a way which may easily become dangerous to his patients." The intelligent citizenship of this country will understand the dangers of socialized medicine if properly presented and will continue to appreciate that the laborer is worthy of his hire.

PAUPERIZATION

There should be no pauperization of medicine any more than pauperization of the merchant, grocer and druggist. There are undoubtedly many angles from which these various problems can be given consideration. It is not within the power of one man or in a single group of men in the field of medicine to outline the fundamental policies of procedure. Many states are giving active consideration to existing conditions. The procedure for meeting the situation will undoubtedly differ in certain aspects in the different states depending on the method of procedure that has been carried into effect these many years in the handling of certain types of dependent people as far as medical care is concerned.

It would appear, therefore, that one of the first steps towards the prevention of generalized social medicine would be for each county medical society to select a committee to study the problem in all its aspects. This committee may be called a public relations committee. Great care should be exercised in the selection of the personnel of such committee. The duties of this committee would be to work out a procedure as to an educational program. It will also make contact with public officials and various welfare agencies. It will interest itself in community problems especially pertaining to health and general welfare. It will bring the entire medical profession in as a part of the body politic. It will help solve many of the minor problems that are agitating local governing officials and by finding a proper solution to the minor problems undoubtedly the larger and vital problems will be held in abeyance or entirely eliminated. It will be able to guide legislation in both community and state. Its first application of procedure should be simple and fundamental and probably should concern itself with solving the medical care of the indigent by an official county system working with the county medical society, thereby reducing in the state the 900 official units that are concerned with the indigent problem to 71 units. Social agencies should be given that aid and assistance that may be compatible to meet existing conditions and be guided by this public relations committee. The objectives of the health department in the larger communities should be better understood and a plan for closer cooperation should be made manifest. The known scientific preventive procedure should be handled in the main as a community problem and not left entirely to the individual family and the family physician.

For a century vaccination against smallpox has been known, but in its general application little advance has been made. Toxin antitoxin could be similarly classified. The monetary consideration is minor no matter how these problems are handled when compared to its effect in abating the tendency to socialization of medicine. The principle should be well established that the medical profession is to be paid for services rendered. Whatever the sum may be is secondary to the establishment of the fundamental principle in the minds of the governing body and the citizenship as a whole that the medical

profession should not be pauperized and, lastly by education and cooperation take care of the devotees of the health institutes at home and let the $15.00 or $25.00 annually paid by individuals, pad your own pockets rather than by turning over to one of the major factors that is practicing and advocating socialized medicine.

It may be said that these suggestions are an argument for the socialization of medicine. Such, however, is not the fact. It is simply an argument for the proper organization of social medicine that already exists. In view of the fact that it is estimated that 70% of our citizenship does not get the proper medical care at the time it is needed, we must admit, if this be true, that something is wrong with the present system. It would not appear, however, that general socialization of medicine would be the remedy. The remedy appears to be in the education of the public to the value of proper medical care at the proper time whether it be preventive or curative medicine. Organized medicine and all of its subdivisions must assume this responsibility if it is to maintain its independence. I believe the county units, backed by the state and national societies, hold the main key to the situation.

Experiences Under The Contract System of Caring for the Indigent Sick

By GEORGE B. LARSON
Secretary Polk County Medical Society
Frederic

For one year peace and harmony have existed between the Polk county physicians and the poor relief authorities of Polk county. On November first, 1931, the Polk County Medical Society concluded one year's operation under the contract system of caring for the indigent sick. We were well satisfied with the system and have no regrets. It was a worth while experiment.

Prior to the adoption of the contract system in Polk county, the members of the Society were wrangling constantly with the poor relief authorities to secure authorization to care for an indigent patient. Often times after procuring authorization it was very difficult to secure payment for services rendered, and if, eventually, payment was obtained the bill was cut without thought of the services rendered.

As a group, we have always "bucked" every type of poor relief advanced by the laity without offering any constructive alternative. By chance we read of the "Iowa Plan" in the American Medical Association Bulletin and from the material received from the Iowa State Medical Society we developed, with the aid of the legal counsel of the State Medical Society of Wisconsin, the contract which appeared in the 1931 June issue of the Wisconsin Medical Journal.

The two points which sold the county committee on this contract were: First, the saving of time and effort on their part of auditing and evaluating the medical bills. Second, the letters of satisfaction of Iowa poor relief agencies where the system has been in effect for a number of years.

We offered to care for the indigent sick in Polk county for one year for the sum of $2,500 (the population of the county is 26,000). We determined this figure in two ways: first, by taking the total amount paid for medical and surgical services during the previous year and adding to that the amounts cut from reasonable fees and disallowed bills, and second, we bartered for the highest possible figure we could secure from the committee, having in mind the type of service we were anxious to render to the indigent.

We agreed to render medical and surgical care (obstetrics excluded) for all indigent patients sent to us by the members of the county committee. The designation of county patients was to be made by the poor relief authorities. We were protected on our major surgical cases with a clause in our contract which made the expense of hospitalization fall upon the county. This acted as a check to prevent the poor relief authorities from bringing unnecessary surgery to the members of the Society. Contrary to the expectations of some members of the Society, the poor relief committee did not ask us to render services to patients that were not

worthy of charity, and patients were not urged to take advantage of this free medical service. We found the committee to be very cooperative and in many cases attempted to prevent pauperizing the people by securing some compensation for our services from the patients.

Practicing physicians in Polk county had one of two experiences under the old system of caring for the indigent sick. Either they took care of them and forgot about their compensation or they spent from three to four hours telephoning for authorization. No one person was vested with authority to bind the county to pay for the work. The result was that the final answer over the phone was a provisional authorization telling you to render the services, and if, upon investigation, the person was found to be indigent the county would pay the bill. The bill, when presented for payment, was turned down saying that the patient was an able bodied man and should be able to pay his own bills. The doctor was out his telephone tolls, time and effort. Several members of the Society have started suit to collect on bills of this type in hopes of creating a precedent in Polk county as to what constitutes an indigent person.

BETTER SERVICE

The poor in our county were given better service under this contract than under any previous system. There were no cases that wanted for relief due to question of authorization or thought of pay. If an indigent patient appeared at the office of one of the members of the Society, he was given prompt and efficient service. If an emergency occurred the patient was taken care of immediately and authorization was secured after the services were rendered, and even if the case needed hospitalization, there was no hesitancy. The committee seemed to feel that the bill was paid and all they needed to do was acknowledge the fact that they were indigent so that the doctor could secure payment for his services from the Society.

When the contract was put into effect a schedule of prices was agreed upon by the members of the Society and all bills mailed to the Secretary conformed to the prices agreed upon in the schedule. Bills for services rendered were mailed to the Secretary immediately after the case was dismissed. At the conclusion of the contract the bills for each individual member were totaled and then a grand total of all bills was taken. This final total amounted to $6,300. The difference ($3,800) is evidence enough that the indigent sick were cared for well. The expenses of running the society for the year, the members' dues for the coming year, the secretary's salary and a balance for the coming year were deducted from the original sum received. The balance remaining to be divided among the members allowed a payment of 30.5% of their bills according to the predetermined fee schedule. This was prorated according to the volume of work done.

The result was that we did this work at a price far below a reasonable fee. It was an experiment to solve the question of caring for the poor and, as such, was a success. We attempted to secure a renewal of the contract with the new poor relief group but failed to agree on a price. The group with which we made the contract was discarded by the county board and a different type of county relief instituted. We offered a contract for the next year at $4,500 and later reduced the figure to $4,000. The poor relief committee refused to go higher than $3,500 and the members of the Society decided that they could not work for that amount.

FAVORABLE ASPECTS

There are two distinct points in favor of a contract to care for the indigent sick. First, a spirit of cooperation and harmony supplants the continual wrangling over payment of bills and authorization of indigent relief. The contract places the work on a business basis and thus gains the public regard for the medical profession when they see that we are able to do business with the county without constant argument. A chronic fighter gains the respect of no one. Second, the contract gives the Society a working fund with which they are able to develop better meetings and carry on educational campaigns.

We have been able (through this fund) to develop a constructive public health program.

The most practical accomplishment of the public health plan was a county-wide diphtheria immunization program, in which approximately 2,500 children were immunized. The Society has developed a weekly health column and secures space in practically all papers in the county. This was made possible by entertaining the editors at Society expense and discussing our problems. The school clerks, women's organizations and other lay groups have been circularized with health information by direct letters. In short, the laity has come to look upon the Polk County Medical Society as a source of medical information. It would have been impossible to have secured funds for this work by assessment of members, as assessments have a tendency to disrupt any organization rather than uniting it into a whole.

This fund has united us into a more concrete body ready to meet oncoming problems of organized medicine. There is nothing today that is so evident in the medical profession as the lack of organization among the county medical societies. The county societies should be so well organized that, at the command of the leaders of the State Society, we would move as a body.

The Polk County Medical Society recommends the contract system as a means toward that unity.

Minutes of the Council, University Club, Milwaukee, 9:45 A. M., January 9th, 1932

1. **Roll Call.** The Council was called to order at 9:45 A. M. by the Chairman, Dr. Arthur W. Rogers, Oconomowoc. Roll call showed a quorum present as follows: Councilors Rogers, Stang, Pope, Blumenthal, Beebe, Johnson, Cunningham, Gavin, Redelings, Joseph F. Smith, Harper and Heidner; President Fiedler, Treasurer Sleyster, President-elect Jackson, Dean C. R. Bardeen, Dr. W. D. Stovall and the Secretary, Mr. J. G. Crownhart. Other attendants during the meeting were Dean McGrath, Speaker Seeger, Dr. John Huston, Dr. Oscar Lotz, Dr. H. P. Greeley, and the following officers of the American Medical Association: Dr. Olin West, Secretary and General Manager; Dr. Morris Fishbein, Editor of the Journal of the American Medical Association, and Mr. Will Braun, Business Manager.

2. **Approval of Minutes.** Moved by Pope-Cunningham that the minutes of the September meeting as published in the Wisconsin Medical Journal of December, 1931, be approved. Carried.

3. **Election of Chairman.** The Secretary called for nominations. Moved by Stang-Blumenthal that Dr. Arthur W. Rogers of Oconomowoc be the choice of the Council to succeed himself. There being no other nominations, the Chair declared Dr. Rogers elected.

4. **Election of Secretary.** Moved by Smith-Redelings that Mr. J. G. Crownhart be re-elected Secretary of the Society and Council. Carried.

5. **Election of Treasurer.** Moved by Johnson-Blumenthal that Dr. Rock Sleyster of Wauwatosa be re-elected Treasurer of the Society and Council. Carried.

6. **Report of the Treasurer.** Dr. Rock Sleyster presented the following report which was adopted upon motion of Stang-Smith.

TREASURER'S REPORT
STATE MEDICAL SOCIETY OF WISCONSIN
as at December 31, 1931

	Gen. Fund	*Med. Def. Fund*
Balance January 1, 1931	$ 250.45	$ 1,950.26
Receipts during year 1931	34,939.61	2,760.00
	$35,190.06	$ 4,710.26
Disbursements during year 1931	34,416.88*	3,174.49
Bank Balance in Funds Dec. 31, 1931	$ 773.18	$ 1,535.77
Recapitulation of Funds		
General Fund:		
Bank Balance Dec. 31, 1931	$ 773.18	
Investment Securities	25,000.00	25,773.18
Medical Defense Fund:		
Bank Balance Dec. 31, 1931	$ 1,535.77	
Investment Securities	7,000.00	8,535.77
Total Cash Resources at Dec. 31, 1931		$34,308.95

Investment Securities

General Fund:		
Northern States Power Co. 1941	5%	$ 4,000.00
American Tel. & Tel. Co. 1936	4%	4,000.00
Wisconsin Public Service 1942	5%	3,000.00
T. M. E. R. & L. Co. 1961	5%	2,000.00
Milwaukee Gas Light Co. 1967	4½%	2,000.00
Canadian Nat'l. Ry. Co. 1969	5%	2,000.00
City of Milwaukee 1936-37	4½%	3,000.00
Ironwood & Bessemer Ry. & Lt. Co. 1936	5%	1,000.00
Beloit Water, Gas & Elec. Co. 1937	5%	1,000.00
Wisconsin Power, Lt. & Heat Co. 1946	5%	1,000.00

St. Joseph's Congregation, Racine 1941	5%	1,000.00	
N. Y. State Elec. & Gas Corp.--1980	4½%	1,000.00	25,000.00
Medical Defense Fund:			
Commonwealth Edison Co.-1957	4½%	$ 2,000.00	
Bell Telephone Co. of Canada ---1955	5%	2,000.00	
Pacific Tel. & Tel. Co.----1937	5%	1,000.00	
North American Co. -------1961	5%	2,000.00	7,000.00
Total Bonds			$32.000.00
Analysis Medical Defense Fund:			
Bank Balance Jan. 1, 1931---		$ 1,950.26	
Receipts, dues		2,470.00	
Receipts, Interest on Bonds--		290.00	4,710.26
Paid to Attorneys		$ 1,234.49	
Bonds purchased		1,940.00	3,174.49
Bank Balance Medical Defense Fund Dec. 31. 1931			$ 1,535.77

* This item of Disbursements includes the sum of $5,058.22 for Bonds purchased, leaving the net amount of disbursements for current expenses $29,-358.66.

7. **Report of the Secretary.** Upon motion of Stang-Pope the following report of the Secretary was accepted:

REPORT OF THE SECRETARY-MANAGING EDITOR

To the Council:

Supplementing the report presented at the September Annual Meeting, your Secretary outlines further progress of the Society's work herein:

Membership

Based on our experiences nine years ago when the dues were increased from $4 to $9, we anticipated that the current increase would bring about a net loss of 200 members for the year. During the calendar year we lost 33 by death and 116 by failure to pay dues, of which number eight resigned by reason of removal from the state. We gained 144 new members and membership as of December 28th was 2127 as compared to 2200 on December 31st, 1930, a net loss of but 79.

With the exception of Minnesota, whose state dues are also $15, Wisconsin records the lowest loss in membership of any of the Northwestern states.

Budget

Just as the budget for the current year was restricted to those activities that we knew were based on sound judgment, so does the proposed budget for 1932 contemplate only those expansions wherein we know that the results to be obtained are tremendously worthwhile and the way proven. Your Budget Committee consisting of the Chairman of the Council, Dr. Arthur W. Rogers; the Treasurer, Dr. Rock Sleyster; the President, Dr. Otho Fiedler, and the Secretary presents its report to you herewith as Addendum A.

Wisconsin Medicine

Since the September meeting your Secretary is happy to report these further results in the constant effort to bring post-graduate education within the reach of every member:

1. A course at the University of Wisconsin in urology for the general practitioner. This course, consisting of one-day periods spaced over five months, was announced in the December issue of the Journal. Registrations promise its complete success.

2. Plans have been complete for three post-graduate courses in the summer of 1932 as follows:

a. Two twelve-week courses in obstetrics and gynecology.

b. One twelve-week course in pediatrics.

3. With the approval of the Governor, the State Emergency Board has made an appropriation of $500 this year, and a like amount for next year, to enable the Medical Library to continue its essential services. This Library now fills upwards of 10,000 requests a year from physicians throughout the state.

4. Dr. John Huston of Milwaukee is now serving as Medical Editor of the Journal at an honorarium of $600 a year.

5. While funds at the University of Wisconsin are depleted for the expenses of lectures before the county societies, through the cooperation of Dr. Bardeen and other officers, it is believed that additional appropriations will be available in 1932. In the meantime many are fulfilling engagements without expenses from either the University or county society.

Special Legislative Session

Upon presentation of the facts by your Secretary (acting in his joint capacity as Secretary of the Wisconsin Hospital Association) all pending legislation to restrict hours of labor exempts those who care for the sick in the 150 hospitals throughout the state. This is the sole exemption in the bills. Twenty other amendments have been rejected. Careful estimates indicate that, had not this exemption been granted, something over $600,000 would have been added to the costs for the institutional care of the sick in 1932 alone. Any such sum would not only have been a tremendous hardship to the sick at a time when they would be least able to bear it, but also might have been reflected in an almost like decrease in compensation to physicians if we may assume that costs of illness are already at the maximum figure with respect to ability to pay on the part of the ill.

Under bills pending on the subject of revision of poor relief laws, your Secretary and counsel have been able to offer suggestions, now incorporated in the measures, that will perfect the means of rendering adequate medical relief in emergencies to those under charge of municipalities or counties.

Care of the Veteran

Your President, as Wisconsin Chairman of the national committee on this subject, will make a special report to you on the progress that has been made

looking forwards authorizing care of the veterans in local institutions by the family physicians, affording a service that is greatly needed but not presently available.

Research Studies

Preparatory to the work of the Special Committee on Distribution of Medical Services, the office of the Secretary is making research studies which comprehend costs of care at the State Hospital; distribution of physicians by counties; hospital facilities including compilations as to open and closed staffs, facilities for rural practitioners, etc.; incomes of residents of Wisconsin, and other studies of like nature. The sole purpose of these studies is fact finding to aid the Committee in its work. Preliminary reports were mailed to the Council on December 23rd.

The Wisconsin Medical Journal

A financial statement for the calendar year is attached as Addendum B. It is to be noted that the Journal loss for the year was less than $350 which has been covered by appropriation from State Society funds. So long as the Journal continues to maintain its high standards for advertising, it seems probable that it will continue to incur loss during the current period of economic stress. This might be avoided by reducing the page content but the Board does not recommend this procedure. Over a period of the last six years the Journal has been published without cost to the Society, a record that is equalled in but one or two other states. Even with the added appropriation for improving the Journal as recommended by the Editorial Board, the costs of publication to the membership will still be under that in practically all states publishing like journals.

Public Education

The Press Service of the Society continues to supply upwards of 300 daily and weekly papers of the state with a weekly health story. In addition, the Assistant to the Secretary is broadcasting twice a week over Madison stations and the material thus prepared is now being furnished for like talks over stations at Sheboygan and Stevens Point. Weekly broadcasts in Milwaukee over WTMJ are under the direction of Mr. Theodore Wiprud, Executive Secretary of the Medical Society of Milwaukee County. Further extension is in progress. Hygeia has again been presented to some 283 state officers and prominent and interested laymen as a means of acquainting those who must pass upon the merits of health problems with the accomplishments of scientific medicine and its future aims. The distribution of these subscriptions was made the subject of a special report to the Council on December 19th. Hygeia has now been placed on the "Approved List" by the State Superintendent of Schools for grade and high schools in Wisconsin.

Other Services

It is not possible here to describe the many group and individual services to members that bring to the headquarters each day large numbers of individual requests and communications. Letters of appreciation indicate that such services are of value and frequently the service to the one may be made available to the membership at large. This was notably the case with the general letter of warning on collection agency methods and a second on unwarranted requests by insurance companies for fee reductions based on misstatement of fact.

Economic Problems

Accomplishments of the Society in recent years have more than paid the annual dues of the members in perpetuity. Your Secretary, however, is keenly appreciative that the present economic conditions which bring tremendously added responsibilities to the executive officers, also bring to the individual member the necessity for economies and retrenchment.

We are presently witnessing many socially-minded efforts which have as their desideratum a better degree of economic security for all people. In these there has been a distinct leaning, on the part of many, towards segregating the distribution and costs of medical care as a single problem with the thought that a better distribution on some assured economic basis would go far towards providing such general economic security. A solution to such a problem cannot be attained independent of consideration of all basic economic problems. Yet efforts for independent attainment are tremendously increased during this period when numbers of indigent or semi-indigent have reached large proportions.

Your President has wisely nominated a special committee which, with the aid of the headquarters, will devote themselves to special study and fact finding in this field. Lack of support of any such effort as this will find the medical profession without the data that is so essential if any change in methods of distribution is to confer an actual benefit upon the public. As your President of sixty years ago so well pointed out, "the danger in transition periods is the tendency of the human mind to oscillate in extremes."

Extremes in just minor enactments may well destroy the greatest benefits that have presently accumulated to the public from independent practice. Your Society will endeavor to speak for the group that we may ourselves continue to recommend every worthwhile advancement; to defeat the ill-considered or ill-timed proposals which however well-intentioned, would result, not in a cheaper perfected service, but in a perfection of cheapened service.

Conclusion

Appreciative that the Society will prosper best as it employs frequent opportunity for submission of its work and aims to the constructive criticism of the members who make possible its every accomplishment, this report is submitted not alone for the information it contains, but for your suggestions and directive action.

Respectfully submitted,

GEORGE CROWNHART,
Secretary-Managing Editor.

28 December 1931.

Addenda:

A. Report of the Budget Committee.

B. Report of the Wisconsin Medical Journal.

C. Order of business for the Council meeting.

D. Study of cash incomes of Wisconsin residents by counties, 75 pages.

Addendum

Financial condition of the Wisconsin Medical Journal

The Journal, while owned wholly by the Society, maintains a separate set of books and its own financial set-up that costs of publication may be known at all times, not possible without such segregation.

The Journal thus pays its share of the rent, of the salary of the Secretary-Managing Editor, postage, supplies, and for its own book-keeping and annual audits.

The present report is for the calendar year 1931.

INCOME:	
Advertising (December estimated)	$9,157.09
Subscriptions	100.55
Misc.	59.00
Interest	45.00
Publishing of proceedings	225.00
	$9,586.64
EXPENSES:	
Salaries (J. G. Crownhart, $1200; John Huston $600 per year, and misc.)	$ 1,740.00
Printing	6,585.15
Mailing	453.59
Cuts	414.00
Rent	300.00
Misc.	163.26
Supplies	20.90
Sub. to other Journals for Med. Ed.	21.30
Discounts allowed	25.80
Depreciation of equipment	9.80
Collection expense	14.50
Accounting and legal	235.00
	$9,983.30
Appropriation from State Medical Society	$1,000.00
Operating loss, 1931	621.66
Credit balance	$ 378.34

8. **Approval of Mail Ballots.** a. Moved by Smith-Stang that the 1931-32 dues of Dr. C. A. Dawson of River Falls, State Commander of the American Legion, be refunded as expressing the appreciation of the Society for his joint services to the profession and public. Carried. b. The Secretary reported that pursuant to Council approval he was presently acting as Secretary of the Wisconsin Hospital Association; that an honorarium of $150 a year was to be paid the General Fund of the State Medical Society by the Association for such services; that because the Association was in such financial position that payment for the first year would wipe out the available cash balance and that for the reason that his work had been of great benefit to the medical profession he suggested that the Council waive acceptance of the honorarium for the first year. Moved by Blumenthal-Smith that the Secretary's recommendation be not accepted. Lost. Moved by Cunningham-Pope that the suggestion be accepted. Carried.

9. **The Budget.** The Secretary, reporting for the Council Budget Committee, presented mimeographed reports upon which the following actions were taken:

1. Rent—The Secretary reported he had been able to secure a reduction from $1,020 to $840. Moved by Cunningham-Redelings that the item be approved. Carried.
2. Supplies, including stationery, postage, misc. printing, telephone, telegraph, office equipment and misc. purchases. The Secretary reported that this cost $2,900 in 1931 but that $2,400 was considered sufficient for 1932. Moved by Stang-Blumenthal that the item be approved. Carried.
3. Press Service, furnishing over 300 papers with a weekly service. The Secretary reported that $2,750 had been budgeted for 1931 of which but $2,462.88 had been used. The Committee suggested $2,500. Moved by Cunningham-Blumenthal that this service be turned over to the State Board of Health. A discussion of the service ensued in which all participated. Roll call was ordered by Chairman. Ayes: Cunningham and Gavin —2. Noes: Rogers, Pope, Harper, Heidner, Beebe, Redelings, Smith, Stang, Johnson and Blumenthal—10. So the motion was lost. Moved by Smith-Pope that the item be continued at $2,200. Carried.
4. Travel of Secretary and Assistant. Cost in 1931 was $675. The Committee recommended $600. Moved by Blumenthal-Redelings that the item be approved. Carried. Subsequently moved by Stang-Heidner-Blumenthal that the additional sum of $400 be allotted for use at the discretion of the Secretary to enable additional visits to component societies. Carried. So the item was set at $1,000.
5. Editorial Board. This item was budgeted at $2,500 for 1931 of which $1,000 was used. The committee recommended $2,500. Moved by Stang-Blumenthal that the item be approved at $1,500. Carried.
6. Annual Meeting. $1,831.01 used in 1931. $1,800 suggested for 1932.
7. Committee on Public Policy. 1931, a legislative year, expenses $2,124.08. Committee recommends $500.
8. Hygeia, 275 subscriptions. Council approved continuation of $500 for this item at September meeting.
9. Delegates to A. M. A. Rail and pullman fare only. $245.01 used in 1931. Committee recommends $240 for 1932. Moved by Blumenthal-Cunningham that items 6, 7, 8 and 9 be adopted as to Committee recommendations. Carried.

10. Secretaries' Conference. Held in April, 1931, at expense of $819.71. To be held in connection with Annual Meeting in 1932. Committee recommends $300. Moved by Blumenthal-Stang that item be approved. Carried.
11. Legal advice and opinions. Expenses in 1931 were $697.75. Recommended for 1932 is $600. Moved by Stang-Redelings that the item be approved. Carried.
12. Committee and Council meetings. Expenses in 1931 were $262.62. Recommended for 1932 is $400. Moved by Pope-Smith that item be approved. Carried.
13. Committee on Cancer. Expenses in 1931 were $500. No appropriation needed in 1932.
14. Foundation Fund. Appropriation in 1931 was $600 of which $225 was used. Recommended for completion of work in 1932 is $250. Moved by Cunningham-Stang that item be approved. Carried.
15. Special Committee to Study Distribution of Medical Services (authorized by House of Delegates). Requested for 1932 — $1,800. Moved by Cunningham-Harper that item be approved. Carried.
16. Revision of model constitution and by-laws for component county societies, $100. Moved by Blumenthal-Stang that this item be approved. Carried.
17. Treasurer, Honorarium, $300. This honorarium goes to the accountant who handles the work of the Treasurer. Same amount as in 1931. Moved by Pope-Stang that this item be approved. Carried.
18. Miss Florence Ripley and Miss Elleanore Beck, assistants in the Secretary's office. Presently receiving $1,680 each. Secretary and Committee recommends $1,700 each. Moved by Smith-Redelings that these items be approved. Carried.
19. Miss Ruth Buellesbach, assistant to the Secretary. Under contract for 1932 at same amount as 1931—$2,100. Moved by Blumenthal-Stang that this item be approved.
20. Mr. J. G. Crownhart, Secretary. For the years 1930 and 1931 Mr. Crownhart has received $6,800 from the general funds of the Society and $1,200 from the Journal, totaling $8,000 a year. (Mr. Crownhart not present.) Council votes to continue salary for 1932 at same figure.

10. Beaumont Memorial. Moved by Stang-Blumenthal that the surplus of $58.07 be transmitted to the Prairie du Chien Chapter of the D. A. R. for preservation of the Memorial or restoration of Fort Crawford as the Chapter sees fit; this in accordance with recommendation of the Beaumont Memorial Committee. Carried.

11. Annual Meeting Dates. Moved by Cunningham-Stang that the dates for the 91st Anniversary Meeting shall be Tuesday, Wednesday, Thursday and Friday (Tuesday business sessions only), September 13th to 16th inclusive. (Milwaukee.) Carried.

Recess. Recess was taken at 12:15 with officers of the American Medical Association as Council guests.

Afternoon Meeting. The Council was called to order at 1:45 P. M. to resume its transactions.

12. Foundation Fund. Dr. Robert Blumenthal, Chairman of the Special Committee reported on the present status of a proposed trust agreement between the First Wisconsin Trust Company and the Society. A separate report by the Secretary on legal elements involved was placed on file. After general discussion it was moved by Pope-Stang that the Committee be empowered to enter into the proposed agreement in the name of the Society after any changes have been effected that appear essential to the working of the Trust. Carried.

13. Censor of Member. The Secretary briefly reviewed the minutes of the September, 1931, meeting of the Council with respect to action taken at that meeting respecting a member charged with having violated medical ethics. Mr. Crownhart then read into the record a report of findings of the Censors of the component society, adopted by the component society, finding the charges not founded on fact. A general discussion followed after which it was moved by Gavin-Stang that the Censors of the ——— County Medical Society be invited to attend the next meeting of the Council to explain the incongruity of their findings with those facts in the possession of the Council. Carried.

14. Cancer Survey. Dr. W. D. Stovall, Chairman of the Committee on Cancer, presented the following report based upon a survey just completed by the Society for the Control of Cancer:

To the Council:

Last year at the January meeting the Council approved the recommendation of this Committee that the American Society for the Control of Cancer be asked to make a survey of the facilities in this State for the care of cancer patients. This survey has been made and the report is before the Council. It seems unnecessary to make any detailed review of the report. The Committee feels that the report is a splendid presentation of an excellent piece of work and furnishes the Society with the information necessary for the laying of plans to attack the cancer problem in a direct manner.

You are all familiar with the activity throughout the world on cancer. Official, semi-official and private agencies have been attracted by its magnitude and have turned their resources into a united effort to combat this menace.

It is surprising that notwithstanding the importance of this disease as a cause of death but few State or municipal health departments have taken any cognizance of it. No official governmental agency has yet claimed this problem as its sphere of activity. The medical profession has, therefore, an undisputed field in which to demonstrate its trustworthiness in the handling of medical problems

which are of public concern and therefore come within the field of Public Health.

This report gives a method by which the problem can be attacked. It is by a joint effort between the State Board of Health, the State Medical Society, the medical schools in the State and the American Society for the Control of Cancer.

Your committee realizes that a beginning must be made; that we can not encompass the whole problem in the initial step. We therefore recommend that in order to take the initial step that the Council authorize the following activities of the Committee:

1. The establishment of a permanent Cancer Committee for the State Society, a majority of the membership never changing in one year. It is suggested that this Committee be composed of at least one member from each councilor district and, when feasible, that the chairman be the State Chairman for the American Society for the Control of Cancer.

2. The organization of a lay auxiliary committee to work with the State Society Committee.

3. Provide for permanent Cancer Committees for each of the component County Societies, a majority of whose membership shall not expire in any one year.

4. Authorize the development of a record system for hospitals receiving cancer patients.

5. Provide for a central tumor registry where tumors removed in various hospitals can be sent for record and filing. These tumors must be accompanied by clinical histories, descriptions of operations, findings at operation and other pertinent matter which the Committee may deem necessary. In order for a hospital to join the tumor registry it will be necessary to provide itself with a record system worked out by the Committee and to be able to supplement this record by a yearly follow-up on each case. The follow-up must be the designated duty of some hospital employee and will be carried out by mailing to these patients or their relative a form letter requesting the information desired.

6. Authorize a meeting at least twice a year of the interested staff members of the hospitals belonging to the tumor registry, the meeting to be called by the Chairman of the Cancer Committee.

7. Provide that the records and tissues on file in the registry be open at all times to members of the profession who wish to use them for study.

8. Discuss with the State Board of Health the advisability of making cancer a reportable disease.

9. Initiate a professional and lay educational program through the co-operation of the agencies and along the lines suggested in the report of the American Society for the Control of Cancer.

10. Authorize the publication of the report in one issue of the State Medical Journal.

11. Authorize the drafting of a set of resolutions expressing the thanks and appreciation of the Council to the American Society for the Control of Cancer and Dr. Rector for the survey.

Respectfully,
W. D. STOVALL, *Chairman,*
Cancer Committee.

14. (continued). Moved by Heidner-Pope that item 11 of the report be adopted immediately and that the Secretary be instructed to communicate the appreciation of the Council accordingly. Carried.

After general discussion of the survey and report, it was moved by Smith-Stang that the survey and report of Dr. Stovall be received and placed on file; that the President of the Society establish and appoint a permanent committee on Cancer with a representative from each Councilor district, the terms of one-fourth of whom shall expire annually; that the Committee be instructed to study the survey and Stovall report taking preliminary steps to ascertain feasibility of the recommendations and reporting accordingly to the next meeting of the Council. Carried.

16. New Business. County Nurse. The Secretary read a communication from the State Health Officer asking for a ruling on the ethics and advisability of making available to the nursing or follow-up staff of lay organizations records of the county nurse, many of which were made available to the nurse by physicians in private practice concerning their own patients because of the co-operation afforded by the county nurse in her official capacity. Moved by Smith-Blumenthal that it is the sense of the Council that information given a county nurse by physicians concerning private patients be not disclosed to any non-official agency inasmuch as maintenance of the confidential relationships between physician and patient is basic to public health progress. Carried.

W. A. T. A. A general discussion arose with reference to the expressed desires of certain component societies to receive information relating to the expenditures of funds solicited from physicians and the public by the Wisconsin Anti-Tuberculosis Association. Moved by Stang-Blumenthal that the Secretary be instructed to secure from the Wisconsin Anti-Tuberculosis Association a statement of expenditures in such detail as will permit the profession to know how the funds are used with particular reference to costs of clinics, costs of solicitation of funds, totals received, amounts retained by local units, salaries of individual employees and officers, and a grouping of expenditures by projects; all data to be requested for the year 1930 or 1931, whichever be available. Carried.

Veterans. President Fiedler reported in detail on the present status of effort looking towards local hospitalization and care of non-service connected veterans of the United States.

Next Meeting. It was agreed that the Council should meet at a date to be selected by the Chairman in the late spring.

Adjournment at 4:50 P. M.

J. G. CROWNHART,
Secretary.

Approved:
ARTHUR W. ROGERS, M. D.,
Chairman.

Building the Public Health Talk*

By H. L. EWBANK, Ph. D.
University of Wisconsin
Madison

The process of speech building does not lend itself to definite rules and precise regulations. The effect of a speech upon an audience cannot be predicted with the same assurance and accuracy with which the chemist foretells the outcome of a simple experiment where all the elements are known and their relations to each other are matters of record. There are too many "unknowns" even in the work of the most skilled speakers.

But, because speech-making cannot be reduced to scientific formulae, it does not follow that it is a completely haphazard process, governed only by the rules of chance. The skilled speaker does not rely on the inspiration of the moment as did a picturesque Southern orator of whom it was said, "He mounted the platform, threw back his head, shined his eyes, opened his mouth and left the consequences to God." The successful speaker knows rather that he is dealing with human beings, infinitely complex in their reactions, but yet subject to the workings of physiological and psychological laws. This series of articles is an attempt to restate some of the laws in terms of the speaker-audience relationship.

Last month we dealt briefly with the first two steps in preparing the speech:

I. Taking Aim; Deciding upon your purpose in making the speech.
II. Diagnosing the Audience.

There are three psychological laws or principles underlying successful speaking that should be introduced at this point: (1) the laws of attention; (2) the principle of reference to experience; and (3) the principle of suggestion.

The Laws of Attention. The most important fact about attention, as far as the speaker is concerned, is that it is not constant. Even when we think we are paying continuous attention, there are "attention waves", spurts of mental activity with rest periods between. One psychologist estimates the average attention period as four seconds; the average rest period as two. But this is only an average. The exact length of the attention wave varies with different individuals according to their education and mental capacity; for the same individual the length is influenced by such factors as the supply of oxygen in the room, interest in the subject, and the degree of fatigue.

What do these attention variations mean in terms of speech style? They mean, in the first place, that only a fraction of the listeners will be attending at any one time, even under the most favorable circumstances. Therefore, if the speaker is to get his idea across to a large proportion of his hearers, he must use repetition. This repetition may be of two sorts: (1) repetition of the same words and phrases, and (2) reiteration of the same thought in different words. Both kinds are valuable, enabling the listener who was inattentive the first time the idea was uttered to hear it the second or third, and serving to fix it more firmly in the minds of those who happen to hear the idea each time it is expressed.

These attention waves also make essential the use of relatively short, simple sentences. If the sentence is long and involved, the listener's attention may not follow you to the end.

In addition to these minute attention waves, there are periods of fatigue that occur after the listener has given close attention for several minutes. The wise speaker, when he sees that his audience is growing restless, changes the tempo of his speech, tells a story to illustrate his point; or, if these fail, brings his remarks to an early conclusion.

The Principle of Reference to Experience. Words are not objective realities that have the same meanings for all listeners. Instead, they are puffs of air, or marks on a page, that must be interpreted by the individual in

(Continued on page 138)

* This is the second of three articles. The first appeared in the January issue.

PRESS SERVICE OF STATE MEDICAL SOCIETY

No serum does so much for public health as printer's ink

ACCIDENTS IN THE HOME

Madison, Wis., Jan. 7—A rug, a cake of soap and a kitchen ladder are instruments of destruction almost as dangerous as the automobile. Approximately 24,000 persons lost their lives during the last year through accidents occurring in their homes. The automobile fatality list was only a little larger. Statistics compiled by the Board of Health of Wisconsin show an increasing number of accidents occurring in the home. Instead of its being a place of safety, due to carelessness it is a place of danger.

"Thousands of the home accidents could be prevented," declares the bulletin of the State Medical Society issued today. "So could thousands of accidents that are less serious, but, are, nevertheless, painful and disabling.

"A weak stepladder is the cause of many accidents. A chair or a box is a dangerous substitute for a good ladder. About one-third of all home falls occur on stairs or steps. Icy steps are especially dangerous.

"There have been accidents caused by poor lighting of stairs and halls; due to a failure to remove snow and ice promptly from doorsteps; due to the lack of a rubber mat near the bathtub; due to matches within the reach of children.

"In a single year there were 74 deaths and 185 injuries in Wisconsin due to the careless use of fires and matches. Four children were burned and one was injured playing with matches. Twelve people died and 14 were seriously injured by throwing gasoline on the fires to quicken them. Twenty-eight hundred children under five years of age die in the United States each year as a result of burns that occur, for the most part, in the home. In a single year, 2,800 people were suffocated in the United States by gas, due to the leakage of gas, or poor ventilation of rooms where gas is burning.

"Bear in mind, too, that a pot may boil over and put the gas out or the wind may blow it out. Sometimes children, playing near a gas stove, will open a burner and leave it open without realizing the danger. One must be on the alert for such emergencies and must turn off the gas promptly.

"The husband and wife can become two of the greatest Evangelists for good health by protecting their own home. Ventilation, sunshine, care of the gas stove, proper attention to electricity and the utmost of caution in using furnaces, matches, and other instruments about the home would cut the death rate from those causes immeasurably."

* * *

SUNBATHS FOR BABIES

Madison, Wis., Jan. 14—Artificially fed babies need more sunshine. In a bulletin issued today the Educational Committee of the State Medical Society advises mothers to put babies in the sun to insure robust health and leave them there twice as long this time of the year as in the summer.

The bulletin declares that children who are artificially fed do not have the vitality to resist rickets and need plenty of sunlight. During the winter months babies need both sun baths and cod-liver oil in order to prevent rickets and to enable their bones to develop normally, according to the Medical Society's Bulletin.

"Every mother who wishes her baby to have robust health should give him regular sun baths from early infancy until he is old enough to play in the sun himself," declares the bulletin just issued. "Sun baths may begin when the baby is three or four weeks old —in warm weather outdoors, in cold weather indoors at an open window.

"If the sun's rays are to help the baby grow properly and to prevent rickets, they must fall directly on the skin and tan it. The rays that tan the skin and prevent rickets — the ultra-violet rays — do not pass through clothing nor through ordinary window glass.

"A baby may have rickets long before his mother notices anything wrong with him. Long before his legs become badly bowed or before other deformities of the bones appear, the disease may have begun to develop. Plenty of sunlight and cod-liver oil at this early stage will save the baby from developing severe rickets and from such results as bone deformities and poor teeth.

"If a child's chest bones are greatly deformed by rickets, this deformity may prevent his lungs from expanding properly and he may be more subject to lung infections such as bronchitis and pneumonia. Besides, a child who has rickets is not able to throw off infections as a normal child does. Thus, although rickets itself does not cause death, it may have complications that do. A severe complication of rickets is a disease called tetany, from which the child may die.

"Longer sun baths are needed at this time of the year because the ultra-violet rays are weak in fall and winter. A winter baby can not get enough sunshine unless he lives in the most southern and sunny parts of the country, so he especially needs cod-liver oil."

* * *

OVERWEIGHT

Madison, Wis., Jan. 21—Fat people may be able to smile more jovially through life but the thin person has a better chance to hang on longer. Facts gathered by the Educational Committee of the State Medical Society of Wisconsin show the disease rate among people overweight is nearly a third greater than those of normal weight.

"Most people have a tendency to put on weight during the winter months when the opportunity for golfing and motoring is denied," says the Medical Bulletin issued today. "There is health in a mile of daily walking and this exercise will help to keep the weight down.

"If we consider for a moment one phase of adult life, and that is the question of weight, the importance of this will be readily made manifest. Life insurance companies have made careful studies of this problem, largely as a matter of business sagacity. Findings have been published from time to time. It has been found that if you take the average death rate of the so-called normal group, a big avenue for consideration will be opened up. The overweight compared with the normal has 151 per cent mortality from heart disease; 172 per cent from nephritis; 165 per cent from arterial diseases; 157 per cent from cerebral hemorrhage; and cancer only 111 per cent. If we go a step farther, we find that overweights are especially susceptible to sclerosis of the liver, the devastating influence of influenza, more subject to paralysis, endangered by angina pectoris, and even in the field of suicides the death rates of overweights are higher than the average.

(Continued on page 134)

THE JOURNAL BOOK SHELF

Surgical Pathology of the Genito-Urinary Organs. By Arthur E. Hertzler, M. D., surgeon to the Agnes Hertzler Memorial Hospital, Halstead, Kansas; professor of surgery, University of Kansas. 222 illustrations. J. B. Lippincott Company, Philadelphia.

Approved Laboratory Technic. Prepared under the auspices of The American Society of Clinical Pathologists by John A. Kolmer, M. D., Dr. P. H., professor of pathology and bacteriology, Graduate School of Medicine, University of Pennsylvania; professor of immunology and chemotherapy, School of Medicine, Temple University; head of Department of Pathology and Bacteriology, Research Institute of Cutaneous Medicine; and Fred. Boerner, V. M. D., associate professor of Bacteriology, Graduate School of Medicine, University of Pennsylvania. With 11 colored plates and 300 illustrations. D. Appleton & Company, New York. 1931.

Diseases of the Thyroid Gland. By Arthur E. Hertzler, M. D., surgeon to the Halstead Hospital. With a chapter on Hospital Management of Goiter Patients by Victor E. Chesky, M. D., associate surgeon to Halstead Hospital. Second edition, entirely rewritten. Cloth $7.50. C. V. Mosby Company, St. Louis, 1929.

Diathermy. Its production and uses in medicine and surgery. By Elkin P. Cumberbatch, M. A., Medical officer in charge, electrical department, St. Bartholomew's Hospital. Second edition, Price $7.00. C. V. Mosby Co., St. Louis, 1928.

BOOKS RECEIVED FOR REVIEW

A Doctor of the 1870's and 80's. By William Allen Pusey, sometime President of the American Medical Association and of the American Dermatological Association. Charles C. Thomas, Publisher, Springfield, Ill. 1932.

A Non-Surgical Consideration of Prostatic Enlargement. Including a lecture on the myth of the bladder neck bar. By Edwin W. Hirsch, M. D., associate in urology, College of Medicine, University of Illinois; urologist, Englewood hospital, Chicago; member, American Urological Association, Chicago Urological Society, and American Medical Association. Price $2.00. Bruce Publishing Company, Minneapolis and St. Paul, 1931.

The Human Voice, Its Care and Development. By Leon Felderman, M. D. Price $2.50. Henry Holt & Company, One Park Avenue, New York City.

Primer on Fractures. Illustrated. Prepared by the Cooperative Committee on Fractures. Under auspices of Section on Surgery, General and Abdominal and Section on Orthopedic Surgery in cooperation with Department of Scientific Exhibit of the American Medical Association. Second edition, revised and reedited. American Medical Association, 535 N. Dearborn St., Chicago, 1931.

History of Medicine in the United States. By Francis R. Packard, M. D., editor, Annals of Medical History. In two volumes. Paul B. Hoeber, Inc., New York. Price $12.00.

Courts and Doctors. By Lloyd Paul Stryker. Price $2.00. The Macmillan Company, 60 Fifth Avenue, New York, N. Y.

A Text-Book of Clinical Neurology. By Israel S. Wechsler, M. D., professor of clinical neurology, Columbia University, New York; attending neurologist, Neurological Institute and the Montefiore hospital, New York. Second edition, revised. Cloth, $7.00 net. W. B. Saunders Company, Philadelphia. 1931.

Female Sex Hormonology. By William P. Graves, A. B., M. D., F. A. C. S., professor of gynecology at Harvard Medical School; surgeon-in-chief to the Free Hospital for Women and to the Parkway hospital, Brookline, Mass. 131 pages, with illustrations. Cloth, $3.50. W. B. Saunders Company, Philadelphia.

BOOK REVIEWS

Any scientific publication reviewed in this column may be obtained for inspection. Orders for such inspection should be directed to the Medical Library Service, 424 N. Charter Street, Madison, Wis.

Allergy and Applied Immunology. A handbook for physician and patient on asthma, hay fever, urticaria, eczema, migraine and kindred manifestations of allergy. By Warren T. Vaughan, M. D., Richmond, Va. Illustrated. Price $4.50. C. V. Mosby Co., 3523 Pine Blvd., St. Louis, Mo.

According to the author, probably at least 10 percent of the population of this country manifest symptoms of allergy. Hay fever and asthma afflict some three millions of individuals. A large number of other pathological conditions may be attributed in part, at least, to allergy. The magnitude of the problem has become apparent in recent years through the active leadership of a number of brilliant clinical investigators. On the one hand they have discovered methods of protecting the allergic individual from the physical troubles to which he is heir. On the other hand they have discovered an allergic basis for many conditions not hitherto attributed to specific hypersensitivity to substances with which the body comes in contact. Numerous books have recently appeared dealing with various phases of the subject. The volume under review written by a master in this field of work, treats of allergy from the point of view of the importance of intelligent cooperation between patient and physician. "This volume", the author states, "is intended solely as a handbook for the patient and not as a text-book for the physician". From this point of view he endeavors to use non-technical language.

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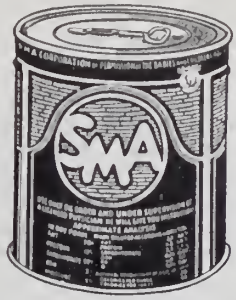

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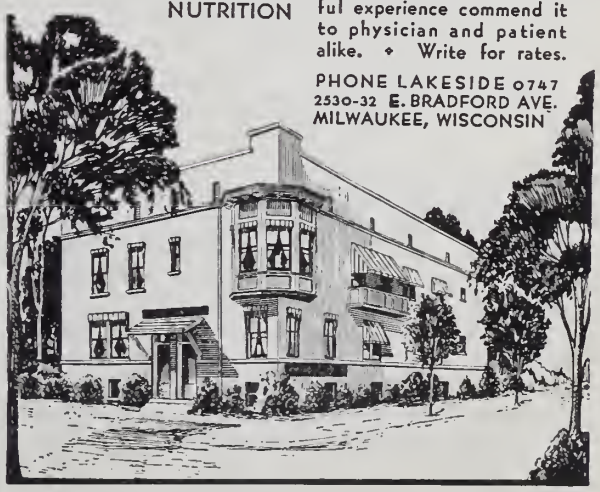

Thus when the term "ureters" is used they are defined as "those small tubes that connect the kidneys with the bladder". Nevertheless, the complex relations between allergy and immunology on the one hand and between allergy and the classification and distribution of plants and animals on the other hand lead him at times into the use of language not likely to be clear except to specialists in these fields. On the whole, however, the style is bright and interesting and a large amount of information is well condensed. In another edition it would be well to put the numerous technical tables and charts at the end rather than to scatter them through the text.

There are few physicians who would not profit from reading Vaughan's "Allergy". With the rapid education of the public along lines of scientific medicine the busy practitioner is put to it to keep up. The layman reads up on the conditions with which he is personally concerned. The general practitioner has a broader field to master.

Unlike some allergists, the author gives consideration to the specific peculiarities of the patient as well as to those objects in the environment to which the patient is specifically hypersensitive. So long as the patient maintains an "allergic balance" he does not respond clinically to substances in quantities which, without this balance, upset him. Treatment of the allergic involves not only keeping him away from substances to which he is hypersensitive, "desensitizing" him against such substances and the use of ephedrin and epinephrin during attacks but also the use of hygienic measures to promote allergic balance. The reviewer knows of instances in which such simple measures as bicarbonate of soda in water taken half an hour before meals or disodium phosphate and sodium chloride in a glass of water before breakfast enable some allergics to remain free from attacks when not overexposed to the substances to which they are sensitive. The allergic patient is likely to profit most when he and his family physician cooperate with the specialist in working out the best measures for achieving an allergic balance. The purpose of this book is to promote such cooperation. There is a good bibliography. C. R. B.

Conquering Arthritis. By H. M. Margolis, M. D. Price $2.00. The Macmillan Company, New York, 1931.

The author has attempted the very difficult task of popularizing a highly technical subject. It is apparent, from time to time, that the job proves too involved for even so adroit a writer. Unexplained medical terms creep in from time to time which must baffle the lay reader, since reference to the ordinary non-medical dictionaries will find no definition for the same. In the main, however, the author has succeeded in detaching himself from the strictly scientific viewpoint and has conveyed a message of hope and encouragement to the afflicted arthritics.

For the purpose of clarity it is difficult to understand why the anatomy of the joints should be considered after a dissertation upon types of arthritis and the sources of infection. It would seem more logical that the reader should have some working knowledge of the anatomy and physiology of these parts before he is introduced to their pathology. The author makes an excellent point in the consideration of the patient as a whole rather of his localized articular changes. The International Commission on Arthritis would take sharp exception to his classification, although, of a number of such available for general purposes, the one utilized is as good as any other. The impression one gathers, from a careful perusal of the text, that the repeated reference to materials to be considered later detracts considerably from the lucidity. One cannot help sympathizing with the author when he attempts to discuss the acid-base equilibrium and the chemistry of purine metabolism. It is clearly a difficult task to cover the subject without complete use of the technical terms, and a medical mind must be dissatisfied with the approach utilized by the author. The discussion of focal infections is apparently an entirely satisfactory one from the lay viewpoint and it is heartening to find such strenuous objection to the heedless sacrifice of teeth and other anatomic structures on the mere suspicion of responsibility for focal infection. Perhaps not enough stress is laid on the frequence with which infectious arthritis progresses without interruption, in spite of removal of every possible focus of infection.

The details of treatment might well be deleted from a lay text. The physician will find a much more adequate discussion of such matters in other sources and fear grows to the professional reader that "A little knowledge is a dangerous thing". Self-treatment cannot help but result from the reading of this section by dissatisfied patients to whom this volume is acceptable; and the attitude of criticism toward a prescribed treatment of the attending physician on the basis of authority such as this text must carry, would seem inevitable. True, caution is cited in the use of drugs with such potentialities for adverse effect as cinchophen, but these drugs mentioned can be and are bought without prescription, and certainly this circumstance of itself cannot be condoned. Barring, however, these criticisms, the last of which is the most pointed, the text should serve as a valuable source of information to the layman. Its usefulness to the physician will be limited to those who wish a concise working discussion of arthritis. W. S. M.

Health Protection for the Pre-School Child. A national survey of the use of preventive medical and dental service for children under six. A publication of the White House Conference. Price $2.50. The Century Co., 353 Fourth Avenue, New York, N. Y. 1931.

This volume is one of a series of publications covering the recent White House Conference on Child Health and Protection. It is the report of a survey

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An Introduction To The Literature Of Vertebrate Zoology. Compiled and edited by Casey A. Wood, M. D., LL. D., Collaborator, Division of Birds, Smithsonian Institution. Oxford University Press, London, 1931.

To give this book adequate praise would embarrass both the author and the reviewer. It is thorough, informative and interesting; obviously the work of a scholar. It is of sufficient value to justify our listing of the rather long chapter headings as indicative of its contents.

A. Introduction to the Literature of Vertebrate Zoology. Chapter I. The beginnings of zoological records. Early Greek, Roman, and Oriental zoologists. The earliest medieval writers on vertebrate zoology.

Chapter II. Medieval writers on zoology and their immediate successors. Zoological incunabula.

Chapter III. The renaissance and its effect on the records of zoological science. Publications of natural history societies and museums throughout the world. Some sixteenth and seventeenth century writers on vertebrate zoology.

Chapter IV. The literature of comparative zoology. The systematic classification of vertebrates. Darwinism, its literature, its advocates, and its critics.

Chapter V. Travelogues of explorers. Reports of voyages and scientific expeditions containing descriptions of vertebrates. Journeys of naturalists round the world. Government and private surveys and explorations.

Chapter VI. Forerunners, contemporaries, followers, and successors of Linnaeus. A short account of Linnean literature. Faunal classifications and nomenclature.

Chapter VII. Some fundamental titles in the literature of modern vertebrate zoology. Hand-colored atlases and their makers. Animal painters and illustrators.

Chapter VIII. From natural philosophy to modern biology. The literature of vertebrate zoology from A. D. 1750 to 1850.

Chapter IX. Some important zoological treatises and serials published during the nineteenth century. Monographs on local faunas. Textbooks on zoology. Reports of explorations and surveys. The literature of vertebrate bionomics.

Chapter X. Some important treatises published during the nineteenth century, continued. Monographs on local fauna. Textbooks on vertebrate zoology. The literature of vertebrate bionomics.

Chapter XI. (I). Some important treatises and monographs on ornithology and mammalogy published during the nineteenth and twentieth centuries.

Chapter XII. (II). Some important treatises and monographs on ornithology and mammalogy published during the nineteenth and twentieth centuries.

Chapter XIII. (III). Some important treatises and monographs on ornithology and mammalogy published during the nineteenth and twentieth centuries, concluded.

Chapter XIV. The literature of zoogeography. Vertebrate ecology. Vertebrate paleontology. Animal psychology. Zoological gardens, museums, and stations.

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Chapter XVII. Oriental literature on vertebrate zoology. Codices, printed treatises, and lithograms in Persian, Arabic, and other Islamic languages. Sanskrit and Sinhalese writings. Chinese and Japanese literature on zoology.

Chapter XVIII. Periodicals and serials on vertebrate zoology.

Chapter XIX. Unique and rare printed books, manuscripts, and drawings in the zoological libraries of McGill University.

Index indicis. (Students' and Librarians' Index).

B. Students' and librarians' ready index to short author-titles on vertebrate zoology arranged geographically and in chronologic order.

C. A partially annotated catalogue of the titles on vertebrate zoology in the libraries of McGill University. W. E. S.

PRESS SERVICE

(Continued from page 129)

"From the causes just enumerated it will be found that the underweights were very materially below the average. Heart disease approaches about 81 per cent; nephritis 77 per cent, and diabetes only 64 per cent. It would appear, generally speaking, that people of practically all weights are more or less equally susceptible to cancer.

"In the figures thus far presented you would form the conclusion, very likely, that the underweights had a great advantage, and in some respects they have, over those noticeably overweight. In the underweights, however, tuberculosis is over 200 per cent above tuberculosis in the normal weights, and in the markedly underweight tuberculosis is nearly 300 per cent higher. Pneumonia is more fatal with underweights, being over 110 per cent, than it is in those of normal weights.

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(6 Servings)

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¼ cup cold water.....	....	....	....	....	.....
1 cup milk.....	240.	7.5	10.	12.	.....
¾ cup water.....	....	....	....	....	.....
2 eggs.....	100.	13.	10.5	....	.....
1½ teaspoonfuls vanilla.	....	....	....	....	.....
1 tablespoonful sugar...	8.	....	....	8.	.....
	....	26.5	20 5	20.	370.5

Soak gelatine in cold water. Heat ¾ cup water and milk—add gelatine and stir until dissolved. Separate eggs and beat yolks to lemon color. Pour hot gelatine mixture slowly into egg yolks, cook over hot water until mixture begins to thicken, stirring constantly. Remove from stove, add salt, and flavoring. Cool. When nearly set fold in whites of eggs which have been beaten stiff. Mold and chill.

LEMON DESSERT

(6 Servings)

	Grams	Pro.	Fat	CHO	Cal.
1½ tablespoonfuls Knox Sparkling Gelatine....	10.	9.	....	....	.....
¼ cup cold water.....	....	....	....	....	.....
2¼ cups hot water.....	....	....	....	....	.....
Grated rind 1 lemon.....	....	....	....	....	.....
4 tablespoonfuls lemon juice.....	40.	....	....	4.	.....
2 tablespoonfuls sugar...	16.	....	....	16.	.....
	....	9.	....	20.	116

Soak gelatine in cold water. Add lemon rind to water while heating to boil. Pour over the soaked gelatine to dissolve it. Add lemon juice and sugar; stir until sugar is dissolved. Strain into molds and chill.

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HOME VENTILATION

Madison, Wis., Jan. 28—It may take some courage to have the windows open these freezing nights, but there will be fewer colds and illnesses if the practice is followed. Many of the winter illnesses are the result of bad ventilation and hugging too close to the radiators, the Educational Committee of the State Medical Society of Wisconsin declared in a bulletin out today. The statement estimates that fifty per cent of deaths are due to bad habits.

"If the thought of wide open windows in zero weather is appalling, pluck up your courage and try a small dose first," declares the bulletin. "You will find that it is far better to spend more money for blankets than to incur doctor bills and bills for nurses and medicines. Eight hours of sleep in cool, refreshing, invigorating air is a better stimulant than anything that comes in bottles, no matter what be the claims on the labels. Be careful not to sacrifice your health in attempting to keep the air in sleeping rooms fresh. If sufficient bed clothing or heaters are not available to sleep with comfort, close the window. Nothing is to be gained by trying to sleep when uncomfortably cold.

"It may be that your daily business commands your presence in stuffy, overheated workrooms or offices, where the regulation of the temperature is not within your individual control. It may be that your fellow-workers or employers are not wise enough to appreciate the value, from a business standpoint, of good ventilation in the workroom. If it is your misfortune to be so confined, try to make up for it by giving yourself the maximum amount of ventilation during the hours of sleep. Night is the time for mental and physical upbuilding. It is impossible to purify the blood properly with bad air. It is quite as necessary to bathe the blood with pure air while it is passing through the lungs, as to bathe the body with clean water.

"Sleeping with windows open the year round is a matter of habit and enough bedclothes. Nature intended us to have fresh air to breathe, both day and night. If you have any memories of the old superstition that 'night air is injurious,' put it aside. This, like many another old saying, has no foundation in fact.

"Health results from a proper adjustment of the individual to his surroundings. If not only communicable diseases but all diseases are to be prevented, everyone must learn how to do it, and then give the time and attention necessary to accomplish it. You cannot prevent disease by waiting until you are ill. This is exactly what people always have done, and the result is that disease prevention is still an unsolved problem. Everyone knows the old proverb, 'an ounce of prevention is worth a pound of cure' but too few pay any attention to it. The trouble is, not the lack of knowledge but the failure to intelligently apply such knowledge as we already possess.

"Health is largely a matter of personal cleanliness, good habits, fresh air, recreation, work, rest, and suitable food in sufficient amounts. Scientific health workers recognize that bad habits cause more deaths than germs. It has been estimated that about 50 per cent of our deaths result from diseases caused by bad habits, 40 per cent are due to infection and about 10 per cent result from a variety of causes including accidents and old age."

TRAUMATIC APPENDICITIS

(Continued from page 101)

ing protruded through appendiceal mucosa into submucosa. An appendectomy was performed in the usual manner and patient made an uneventful recovery, leaving the hospital on the tenth day following operation.

CONCLUSIONS

I. Trauma plays an important part in causing appendicitis provided it is in the right location and that symptoms come on immediately following injury.

II. The factors in a case of traumatic appendicitis are:
   - A. Fecal concretion obstructing lumen of appendix or abrasion of mucosa by foreign body.
   - B. Defective drainage.
   - C. Sudden trauma tearing mucosa and leading to acute and often perforative appendicitis.

III. Traumatic appendicitis is to be kept in mind in cases of peritoneal irritation following abdominal injury.

IV. The etiological role of trauma in appendicitis is of importance frequently in Workmen's Compensation cases.

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PHYSICIANS' EXCHANGE

Advertisements for this column must be received by the 25th of the month preceding month of issue. A charge is made of $2.00 for the first appearance of copy occupying 1 inch or less of space and $1.00 for each succeeding insertion of the same copy. Kindly accompany copy with remittance to cover number of insertions desired. Advertisements from members of the State Medical Society will be accepted without charge. Such copy will be taken out after its second publication unless otherwise requested. Where numbers follow advertisements replies should be addressed care Wisconsin Medical Journal.

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PUBLIC HEALTH TALK

(Continued from page 128)

terms of his past experiences. This idea, called by some writers the Principle of Reference to Experience, is formulated thus:

(a) We can only communicate with others in terms of their past experiences;
(b) The more we bring our ideas within the vivid, first-hand experiences of our listeners, the more they will grasp our meanings, and obversely;
(c) The less we bring our ideas within the vivid, first-hand experiences of our listeners, the more meaningless will our ideas seem to them.

To be understood the speaker must choose words with which his hearers are familiar and illustrate his points with incidents drawn from their experiences.

The Principle of Suggestion. This principle, called by some psychologists the greatest discovery of modern psychology, is based upon these two laws:

(a) Every idea of an action will result in that action unless hindered by an impeding idea or physical impediment.
(b) Every idea, concept, or conclusion which enters the mind is held as true unless hindered by some contradictory idea.

The tendency of the average mind is not to weigh and deliberate; it is rather to accept as true any charge that is made unless the individual has evidence to the contrary. This is why rumors soon are repeated as fact, while denials, conflicting as they do with the first impression made by the rumor, are received with much more scepticism. This is why you have found it hard to make progress against the superstitions and misinformation on medical matters that have become so firmly implanted in many minds that they have all the power of eternal truth.

STEP III. GATHERING THE MATERIAL

When you speak on public health topics, you have a wealth of general information available from your professional studies. This is at once an advantage and a disadvantage: an advantage in that it enables you to speak with more conviction and authority than would otherwise be possible; a disadvantage in that you may be tempted to rely on this general knowledge and be too general and abstract in your remarks to suit the demands of the lay audience.

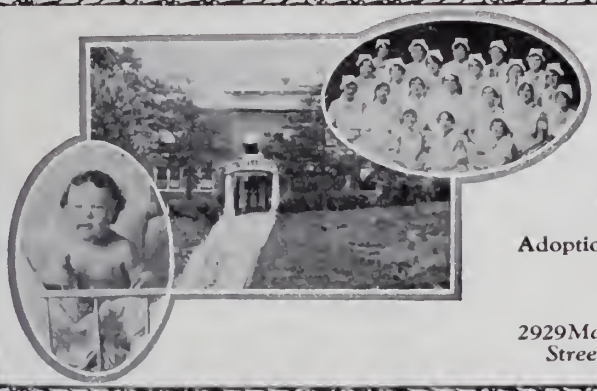
Any one of the following may be used as material for your speeches:

(a) Facts, figures.
(b) Statistics.
(c) Quotations.
(d) Documents.
(e) Reports of committees.
(f) Specific cases, examples.
(g) Illustrations.
(h) Testimony of experts.
(i) Testimony of witnesses.

If you are like most speakers, when you come to prepare for an address you will have lots of general ideas but too little definite material. You will vaguely remember an article that you read somewhere, a telling statement by some eminent authority, some statistics that are just what you need, if you only knew where to look. The best remedy for this situation is to begin, as soon as you make the speaking engagement, to write down as they occur to you all ideas that seem to bear on the subject; to make note of all facts that you discover, all illustrations that you may want to use. The witty sayings, the telling illustrations, the important statistics, the apt quotations, do not come flocking into one's mind as he sits down the evening before the speech is to be delivered, reaches for his pencil and attempts to draw up a plan for his remarks.

STEP IV. MAKING THE OUTLINE

Even before you have all of your material at hand, you will have begun to make some sort of mental outline of the speech you hope to make. This outline should be a record of the plan that you will use in your effort to secure the desired reaction from your hearers. It is not always necessary that this outline be written out, although this is highly desirable for the beginner. Some speakers acquire the ability to think out and memorize a plan without reducing it to writing; but



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this does not mean that they have dispensed with the outline. The outline is just as indispensable to the speaker as the blueprint is to the architect or the plan of battle is to the general.

The following layout will give you some idea of the type of outline that I have in mind:

A. *Introduction.*
  (a) Arouse interest.
  (b) State purpose of speech.

B. *Discussion.*
  I. First Main Point, developed by
    (a) specific cases.
    (b) comparisons.
    (c) statistics.
    (d) expert opinion.
    (e) reiteration.
  II. Second Main Point, developed as above.
  III. Third Main Point, developed as above.

C. *Conclusion.*
  (a) restate main ideas.
  (b) appeal for action.

The main points should be few in number and their connection with the central idea of the speech should be clearly stated. After ten years I can still remember the outline of an address delivered by the late Marion LeRoy Burton, then president of the University of Michigan, before an audience that filled the Hill Auditorium in Ann Arbor. His subject was The Mission of the College, and he made four points:

(1) The college should teach the student to think.
(2) The college should give the student information that will be useful in his life work.
(3) The college should cultivate the student's imagination.
(4) The college should not neglect the student's ideals.

The address was about an hour in length; each point was developed after the manner suggested in the model outline.

If Dr. Burton had divided his speech into eight or ten main heads, the chances are that I would not today remember any of them.

Here are the four main points discussed by Howard W. Haggard, M. D., in a radio address on American Dentistry:

(1) Sins of omission in dental care of children.
(2) Human jaws are like a finely wrought machine.
(3) The temporary teeth shape the jaws.
(4) Children's teeth need the finest dental care.

The order in which these main points are arranged depends, in part at least, upon their relative importance. Research has revealed that audiences remember a larger proportion of what was said in the first few minutes of the address than at any other time. The last few minutes of the address ranked second in memory value and the middle section third.

STEP V. EXPANDING THE OUTLINE

Now we have in mind as accurate a picture as possible of the audience before whom our speech is to be given and of our purpose in making it. We have at hand an adequate supply of materials and, either on paper or in our minds, we have formulated an outline. Our next task, evidently, is to develop the main points into paragraphs or groups of paragraphs, depending on the length of the speech we are to make.

How does one build a paragraph? There is no one universal prescription but it is safe to say that the usual complete paragraph contains four elements:

1. The opening connective.
2. A sentence stating the theme or central idea of the paragraph.
3. Sentences amplifying or proving the theme, providing the answers to the questions that your listeners naturally ask when they first hear your assertion.
4. The conclusion, usually a phrase or sentence which serves to drive home the theme by repeating it with added emphasis.

Note how this is done in the following paragraph, taken from an address dealing with the prevalence of crime in the United States.

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voices of every authority in the land, the indictment that, within the last decade, America has become the most lawless nation on earth. The American Bankers' Association states that losses from bank robberies have increased 400% in the last seven years. William J. Burns, the great detective, states that there is stolen in America each year more than twice the amount spent on public schools. That is, since I began speaking a minute ago, there has been stolen from the people of this country $10,000. The American Bar Association's report states that there are four times as many people murdered in this country each year as were killed in the battle of Gettysburg, and that in the last half century there have been more people murdered than have been killed in all of the foreign wars of this nation. Furthermore, the rate is increasing by 1,000 murders a year . . . "

Here the opening connective is supplied by the word "Yet"; the theme is that " . . . within the last decade, America has become the most lawless nation on earth." The remaining sentences supply striking facts and expert opinions telling of the growth of lawlessness in America. The comparison with other countries and the concluding sentence are not included.

A different method of paragraph development is shown in the following quotation from Dr. Haggard's radio address on Cancer.

"Now what is cancer? Millions of dollars are spent each year in studies carried out in medical laboratories throughout the world in an attempt to answer that question. But today the cause of the disease is not known. Nevertheless much practical and important information has been gained.

"Cancer arises from a disturbance in the growth of the cells of which the body is composed. Each one of these microscopic particles which make up the flesh is a living entity, capable of dividing and producing new cells of its own kind for growth or repair. Under the influence of some controlling forces, concerning which little is known, growth is finally brought to a stop so that the cells of the adult body cease to multiply except for necessary repairs to the tissues . . . "

In each of these paragraphs, the central idea, or theme, is stated in the opening sentence. The first paragraph is properly brief, stating that only an incomplete answer can be given to the question; the second begins the process of recounting the significant facts about cancer that have been discovered in the course of the prolonged and costly research mentioned in the first paragraph. It should be remarked in passing that the style of this address is well suited to the demands of the intelligent layman, the kind of person that would be listening to such an address.

The process of speech building has no magic secret. Given the material and the outline, it is a matter of constructing a paragraph on each of the points made in the outline, and of joining these paragraphs into a unified whole by means of connecting words or sentences. Great skill in speech building rarely comes without considerable practice. E. E. Slosson, author of Creative Chemistry, and a speaker with unusual ability to interpret scientific facts for audiences of laymen, testified that his success was due more to the fact that he spent fifteen years writing news stories than to his training in the facts and methodology of science. It is not to be expected that many of you will have the time or the inclination to devote as much time to speaking and writing as Mr. Slosson did. But if you are willing to devote a reasonable amount of time and thought to the matter you can prepare a public health talk that will be a creditable performance and a valuable addition to the program of your luncheon club or your Parent-Teachers' Association.

Next month, in the third and last article of this series, we will have something to say about (1) Crossing the interest deadline; building the introduction; (2) Making sentences that talk directly to your hearers; and (3) A few notes on delivery.

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The next written examination of the American Board of Obstetrics and Gynecology will be held in nineteen different cities of the United States and Canada at 2 p. m. on Saturday, March 26, 1932. The general, oral and clinical, examination will be held in New Orleans on Tuesday, May 10, 1932, immediately preceding the meeting of the American Medical Association. Reduced railroad fares will be available. For detailed information and application blanks apply to the Secretary, Dr. Paul Titus, 1015 Highland Building, Pittsburgh, Pennsylvania.

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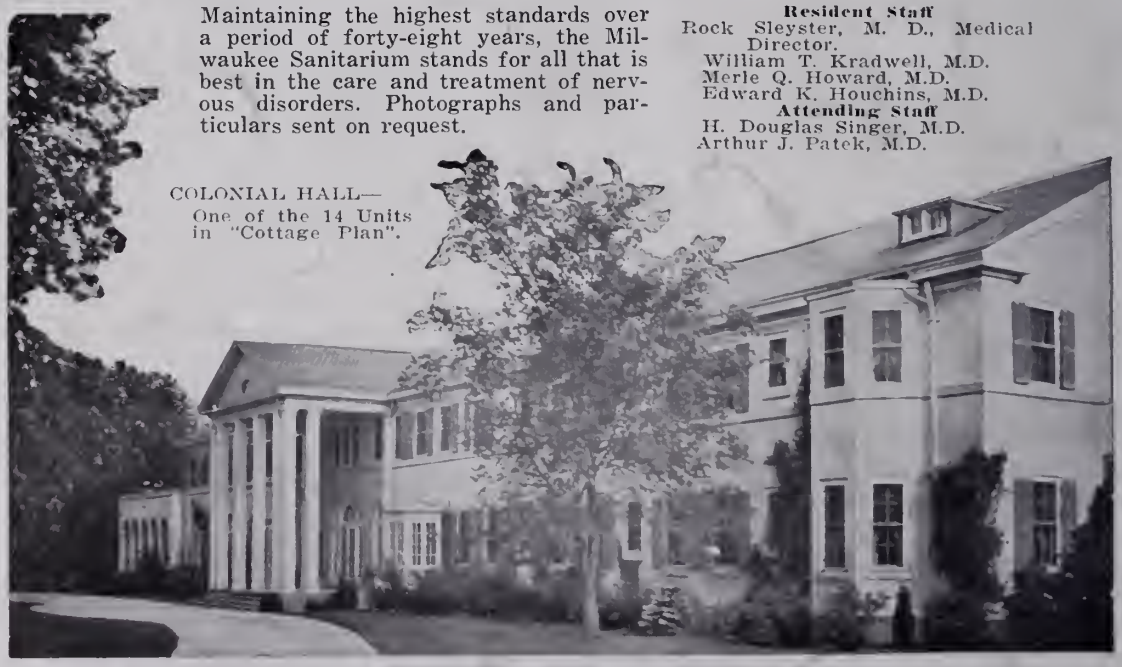

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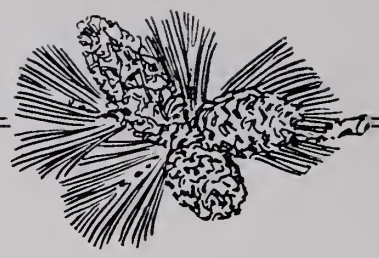

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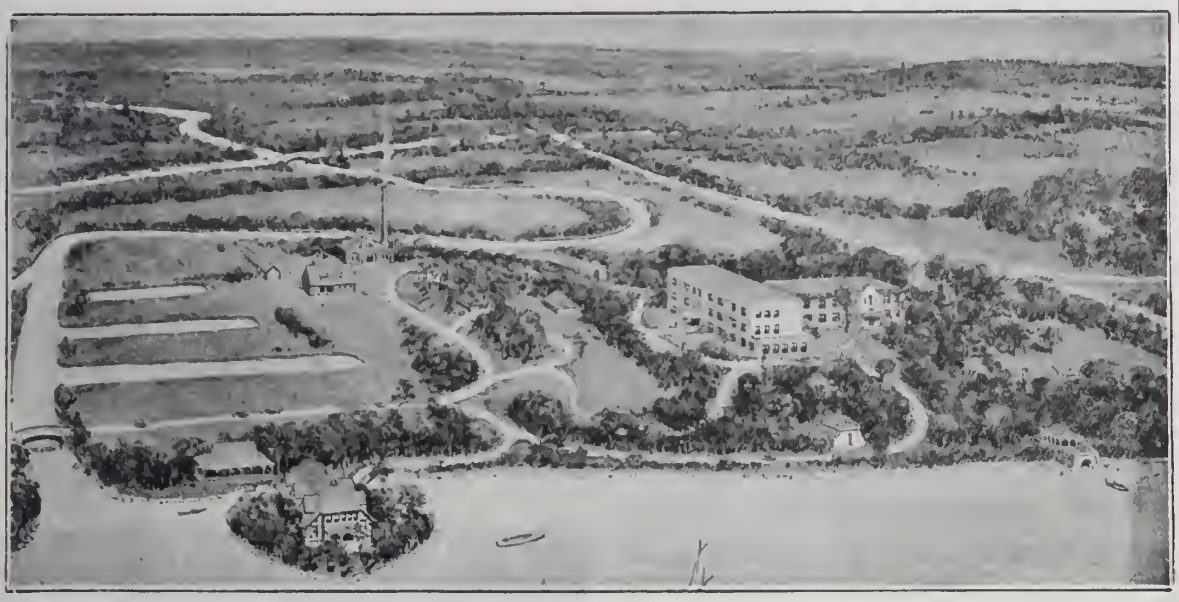

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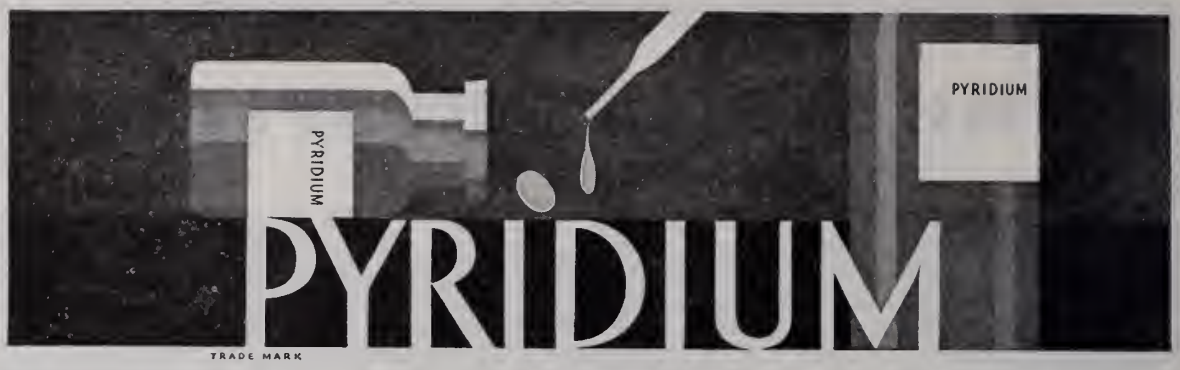

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The Wisconsin Medical Journal

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The Small Community Hospital*

By A. A. AXLEY, M. D.
Washburn

Under the term, small community hospital, we may include all hospitals in localities that are not provided with municipal or county institutions for the care of the indigent; a hospital so situated geographically that it cannot sidestep when the poor and improvident apply for necessary care. Where adequate provision has been made for this class, the expense of hospital care need not be a burden, either to the patient or the regular hospital sponsors.

Primarily, this paper is intended to deal with the hospitals of smaller cities and more or less rural communities, but the probelms of the small hospital are also the problems of the large hospital so it shall not be excluded.

The automobile, the telephone, and the advances in medicine necessitating extensive and expensive equipment, all have contributed their share to concentrate the location of medical men to the natural trading centers. This concentration has in turn increased the distance of travel between the patient's home and the physician, and has materially increased the expense of home treatments in many localities.

In many cases the travel cost is so great that the public has grasped the fact that hospital care plus medical care at the hospital costs no more than medical care at home. There are people in my distant territory who without hesitation bring members of their families in for even more or less minor ailments and leave them in the hospital in preference to driving back and forth to make office calls.

One of my colleagues, a most capable general practitioner, tells me that he has lost practically all of the village and country practice in a town sixteen miles from his office; a community of about eight hundred people in a territory that had always been his. He is the only physician within forty miles. He says "they haul them direct to the hospital forty or more miles away". He still takes care of some of their emergencies and most of the poor. My friend sees the writing on the wall, but what is to be done about it? Ten years ago two physicians made an adequate living in his little city. His colleague died, and now there is not enough left to satisfy one.

In a recent number of the Saturday Evening Post there was an editorial commenting on the demise of the general practitioner. The virtues and kindly interest of the good old family doctor were recognized, but he was severely criticized because he did not feel qualified to do a multitude of things and furthermore did not have equipment with which to do them. He referred away so much of his legitimate income, and so reduced his earnings that he became dissatisfied and developed into either a disgruntled fatalist or a specialist in some larger center.

As a State Medical Society, we are, I believe, striving to give all of the people of the state the best medical service possible under prevailing conditions, and to do it so that as a whole they will like it and approve of our endeavors. Certainly, if we arouse enough dissapproval we will have regulation of our activities.

A few years past our State University claimed that a full medical course was necessary in order to supply adequate medical service to all of our rural and isolated people. The school would teach the young men to practice scientific medicine and then send them out to the public and have them put it into practice. The university probably did lose sight of the fact, at least during its enthusiasm, that unless the young M. D. has a

* Presented before 90th Anniversary Meeting, State Medical Society of Wisconsin, Madison, Sept., 1931.

wealthy father or father-in-law, he cannot equip himself to practice scientifically; he must locate near a hospital or associate himself with an established physician or group of physicians.

Whether or not the young men are now being encouraged to go to these rural districts, I do not know. But I do know that more and more of the people come to the city office or hsopital, that they will travel considerable distances to do so, and that there are many less calls to the homes than there were in the years past. As medical men we must, however, realize that in order to keep the expense and inconvenience of these rural people from becoming objectionable the distance covered must be within reason.

LOCAL HOSPITAL ESSENTIAL

If you wish to have rural physicians be what you desire them to be, they must have places to work. The automobile and telephone have made it possible for physicians to serve much larger territories than was possible in the old horse and buggy days.

There are emergency cases that need special care and who do not bear transportation well; your automobile accident skull fractures, ruptured appendices, and multitudes of others. Some of these cases will do far better under the care of a good general man at a small general hospital than they would under a most efficient specialist after several hours of transportation.

A number of years ago, a friend of mine and a relative of the late Dr. Murphy insisted on going to Chicago for an appendectomy—a distance of four hundred miles. His appendix ruptured on the way down. He was in the hospital for one month draining. He then came home and had to go back a month later to have his appendix out. This desire of patients to have surgeons from distant centers do the operating has, I believe, a bearing on the increased mortality in acute appendicitis.

Every physician who gives this question of rural practice thought will admit the desirability of hospital care within reasonable distance of the people to be treated. In rural districts hospital care is convenient and economical to the patient. It will, without a doubt, make possible the saving of some lives. It will help keep the rural physician up-to-date and in the good graces of his clientele. It will make possible a desirable practice away from the larger centers.

The staff of the small hospital should and will recognize the desirability of referring some of its cases to larger institutions for study and treatment. But the larger institutions should also recognize the fact that some of the cases that come to them direct would have been infinitely better off had they been put to bed or possibly operated several hours earlier nearer home, and should so advise these patients.

Granting that there is a definite field for the small community hospital, what are the greatest obstacles in the path of its establishment and operation? First—the necessary modern equipment. This is a real problem, but the public recognizes the situation and if properly approached can be induced to carry at least a considerable part of this initial outlay.

It is far easier to get donations to establish, build, or equip a hospital than it is to get financial aid to operate one. In Duluth the Miller fund of $600,000 was bequeathed for the erection of a Miller Hospital to care for the poor. No provision was made for its operation. Since the bequest was made enough time has been consumed in vain endeavors to provide ways and means of operation to allow the bequest to grow to approximately $900,000. Under the provision of the will the funds must be used for building; obviously not for operation.

Duluth already has more hospital beds than it can well use. To operate still another hospital will increase the community expense per patient. So we have the travesty of nearly a million dollars begging to help the poor at a time when all hospitals are struggling with difficulties because the sick are now, more than ever, unable to pay.

The small private hospital must of course pay taxes, but that can and should be avoided by incorporating under the laws as a corporation without gain. Obviously there is no direct monetary gain.

CARE OF THE INDIGENT

The real burden on the hospital is not the regular cost of operation or the necessary expense, but the care of the people who cannot pay and those who will not pay. To me it seems absolutely unjust to add to the hospital expense of the provident patient a certain percentage to take care of his improvident neighbor. If the poor must have help, let the burden fall on all of his neighbors instead of on the sick alone who already are loaded with their own responsibilities. The small communities in general have few wealthy people. The public looks askance at the call for aid in financing hospital operating deficits. So this burden falls directly or indirectly on the physicians sponsoring these institutions.

There is the Ashland General Hospital limping along financially; sponsored primarily by that pioneer in medicine and hospital service in northern Wisconsin, that grand lifelong friend of the poor, Dr. J. M. Dodd, still advising his patients "Pay your hospital bill first and you can pay us after awhile." This, of course, helps the collections at the hospital, but it also decreases the legitimate income of this deserving public servant. If Doctor Dodd had collected the money he has contributed in this way and put it out as a donation, he would be considered a philanthropist of note.

The northern part of the state has had a series of difficulties and maladjustments. First, the lands were denuded of their forests and the cut over lands were valued above their true value for taxation purposes. Partially developed farms were grossly over assessed, and as a result a large proportion of all property paid no tax. This did not decrease the amount of money that had to be forwarded to the state, but did decrease the amount left to the towns. This tax delinquency became a vicious cycle and the townships became poorer year after year.

Today we have the town of Sanborn in Ashland County and the town of Russell in Bayfield County that have given notice that they will authorize no more poor aid. These two townships have been especially burdened by small settlements of notoriously improvident people—the Indians. Most of the other townships are also in distress and, although their officials express a willingness to render aid, the funds are not forthcoming.

The Ashland General Hospital has one account of $764.00 against the township of Bayfield. The account is authorized for payment, but it is already three years old, and, unless the Hospital goes to the undesirable trouble of court action, this account will probably outlaw in due time.

Our own small hospital has authorized bills from one to four years old against several townships and they assure us they will pay just as soon as they can borrow the money.

On December 7, 1930, a man sixty-four years old, earning sixty dollars a month, the father of seventeen living children, eight of them of school age, was brought to the hospital with a severe concussion of the brain and a scalp wound that suggested a blow with a piece of gas pipe. He remained semi-comatose for about seven days. On the tenth day he was sent home to rest for a longer period.

The mayor, the city police, the poor committee, the sheriff and the county judge were apprised of the circumstances. No one could be induced to authorize payment of the account. The family stated they could not and would not pay. The man is a respectable, law-abiding citizen and ordinarily pays his just accounts. After two months of rest, he still had lapses of memory and was not in condition to go to work.

I again went to see the county judge about the case, suggesting that the patient be sent to the Wisconsin General, and, without blinking an eye, the judge proceeded to authorize his care and transportation to Madison. The travel expense alone was almost as great as our hospital bill.

Politically, it is safer for the judge to authorize care at the state hospital than at a local hospital. Funds for care at the state hospital are not subject to the same scrutiny by county boards as are local hospital accounts.

We, of course, realize that the Wisconsin General Hospital was not built primarily to take care of the poor; it was established to furnish clinical material for a medical school. We are ready to grant that this is

a justifiable cause and that the hospital does a great service.

The law allows the county judge to authorize the care of certain poor cases at local hospitals, providing the patient is willing and the cost to the county is not greater than it would be at the Wisconsin General plus the railroad fare. Is the cost to the county only the two and a half dollars per day that the county pays direct, or does it include the two and a half dollars per day paid by the state and indirectly bourne by the county? Why should any hospital be required to take care of authorized county cases at about half of what it costs to take care of them at the Wisconsin General Hospital? Bear in mind the fact that we are not endeavoring to keep these cases, but when we must take care of them, why should we be penalized?

Since the county judge has been authorized to provide care for a goodly proportion of the poor, the township system of poor relief should be discarded by statute. Divided responsibility generally results in no responsibility. Let the county judge or some other agent, if necessary, administer poor relief for all the county. People of doubtful means should be considered indigent so far as hospital service is concerned unless proven otherwise, and the burden of proof should rest with the county officials. The county should have authority to collect and should collect from patients who have received aid when conditions make repayment possible. The present system of bickering with town authorities is a disgrace to our American intelligence and justice. Proper administration of poor relief will go far toward keeping the medical profession in good standing with the public at large.

The small community hospital is a boon to the people it serves and to the physicians who practice there. It can be maintained if adequate provision is made for the indigent. The state takes some of our poor and treats them at county expense; let us educate our counties to pay necessary hospital expenses for the poor that we are required to accept.

Spinal Anesthesia; Benefits Conferred Upon the Patient and the Surgeon*

By R. H. JACKSON, M. D.
Jackson Clinic, Madison

In order to present my subject as concisely as possible and keep within the allotted time, I shall divide it into two parts. First: The reading of a few pages of notes condensed from the paper as prepared for the Transactions. Second: The utilization of slides and films to bring out and reémphasize certain salient features.

The criteria by which any new surgical method should be evaluated embrace primarily the interests of the patient and secondarily those of the surgeon. The persistent search for a satisfactory anesthesia method which, while insuring the minimum amount of discomfort and danger to the patient, will provide the maximum degree of facility to the surgeon is evidence of the dissatisfaction with general anesthesia. Increasing dissatisfaction lies in apprehension over the possible incidence of postoperative complications.

Scrutinized by the calm eye of long professional experience, the induction of general anesthesia by the potentially lethal narcotic drug, ether, arouses many reflections as to its desirability. It requires 50 per cent of the lethal dose to produce the colloidal changes in the nerve cells of the higher centers which result in loss of consciousness. There is more or less toxic effect on all cellular structures with a vitiation of normal function, proportional to the personal equation of the anesthetist, the duration of the operation, and the resistance of the patient to the mal effects of the narcotic drug. With proper technical spinal anesthesia, the surgeon regains the personal control and responsibility of a most important phase of his work.

It is a method supreme in its ability to provide:

1. Complete anesthesia.
2. Perfect muscular relaxation.

* Presented before 90th Anniversary Meeting, State Medical Society of Wisconsin, Madison, Sept., 1931.

3. Easy induction for the patient and surgeon.
4. Minimum of postoperative complications.
5. Minimum interference with cellular and organ activity.
6. Conservation of patient's reserve nervous strength and psychic control.
7. Limitation of toxicity to a few centigrams of a practically non-lethal drug.
8. Abolition of shock during or after operations due to operative trauma per se.

No known method of anesthesia is free from danger of an occasional death. I have had experience with many anesthetists and have known patients to die on the operating table from chloroform and the mal administration of ether. Patients have died of fright before any anesthetic was administered. Many patients have died of postoperative complications which I now believe were indirectly due to the anesthetic per se. With the steadily increasing number of patients in critical condition who are given a last chance through surgery, an occasional death in the operating room is unavoidable. To conserve the interests of these critically ill patients there has developed in recent years a strong preference for local or direct nerve block anesthesia, as evidenced by its use in strangulated hernia, laparotomies on the aged and debilitated, in patients with respiratory diseases or impaired kidney function and in thyroid surgery, due to the fear of complications if a general anesthetic were to be administered.

Our experience with spinal anesthesia began many years ago when we fearfully used it a few times in patients with diabetic gangrene of the lower extremity requiring amputation, and our impression of spinal anesthesia was decidedly unfavorable.

Ten years ago we used it in a series of prostatectomies. Several patients reacted very unfavorably with alarming drops in blood pressure, nausea and vomiting, cold clammy perspiration, accompanied by extreme pallor, air hunger and fear of impending death. Anesthesia frequently failed to appear or was partial, and resort to general anesthesia was necessary. Fear of catastrophe with inability to control these alarming symptoms forced us to discontinue its use.

Four years ago we again began using spinal anesthesia for amputations of the thigh and prostatectomies. Results were better than past experience led us to expect. We attributed the improvement to the use of pure novocain and the prespinal administration of ephedrin. In the first 50 patients, 10 per cent failure to produce satisfactory anesthesia occurred. Some patients complained bitterly of headaches lasting several days. One patient had an area of paresthesia on one leg. Two needles were broken and had to be dissected out. The nervous strain over what might happen was wearing, especially after hearing that a number of deaths had occurred in Boston, directly attributable to spinal anesthesia. We were constantly visualizing patients with permanent paralysis of the bladder, rectum, legs or sudden death on the table. We were unhappy over the situation, yet loath to give it up as it was an ideal anesthetic from the standpoint of both the patient and surgeon when acting properly.

ACCURATE TECHNIC ESSENTIAL

Checking up revealed one member obtaining uniformly good results. He had ideas and had developed a special technic. When made responsible for all inductions he soon convinced us that previous failures were due to faulty technic. Such a uniformly smooth, accurate, timely anesthesia without untoward symptoms was provided that we became enthusiastic. Dr. Richard Stout had developed an entirely logical, satisfactory volume control method.

Ninety-five per cent of the patients in the first 1,000 inductions expressed entire satisfaction. Those previously operated on under general anesthesia were outspoken in their preference. Five per cent would prefer to be totally unconscious under a general anesthetic. The majority of these were in the initial group of fifty in which unsatisfactory results occurred due to faulty technic. At this time my brother, James, had a postoperative death directly attributable to

Spinal Anesthesia - Dosage Chart

LEVELS	ONE	TWO	THREE
ANESTH.-LEVEL	ILIAC CRESTS	COSTAL MARGIN	CLAVICLE
EPHEDRIN	20-40-Mg.	60-90 Mg.	100-125-Mg.
NOVOCAIN	100-Mg	200-Mg.	300-Mg.
C.C. SPINAL FL.	1.0	2.0-2.5	3.0-3.5
INJECTION-RATE	5-SEC.	10-SEC.	15-SEC.
LENGTH-ANESTH.	1-1½ HRS.	1¼-1½ HRS.	1½ HRS.

1. A condensed outline of the routine method we use to obtain anesthesia of the desired level by varying the amounts of spinal fluid, ephedrin and novocain.

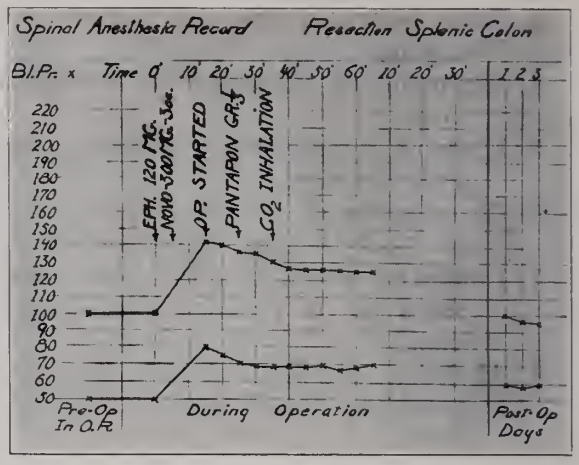

Fig. 2. The method as used in resections of the splenic colon for carcinoma.

spinal anesthesia. Ignorance of the proper remedial measures, which, if taken in time, would have obviated this single mortality in a series of some 3,500 inductions, is lamentable. Time will not permit my reading the details; death occurring on the third postoperative day: a cerebral death-consciousness not having returned following too prolonged a period of anoxemia of the higher centers following respiratory failure. While normal respiratory function had been restored during the operation by the introduction of CO_2 and oxygen into the lungs under pressure, fifteen minutes had elapsed before this measure was used. Seven minutes is the maximum time during which anoxemia of the centers of consciousness may persist with return of conscious cerebral activity, although as in this case a purely vegetative existence may continue for several days. At that time we were using rather small doses of ephedrin and injecting it into the buttock. We believe that in this case the ephedrin was injected into fat and not absorbed. In the last 3,000 inductions in which we have used larger doses of ephedrin and injected it into the muscles of the back, there has not been a single instance of any alarming symptoms.

In this last series of inductions in all operations on the stomach, biliary tract and intestines, the table has remained in the horizontal position. We no longer consider it essential to place the table in the Trendelenburg position as a factor of safety. Our clinical observations with regard to the safety factor of the proper prespinal injection and absorption of ephedrin are fully corroborated by the work of Ravden and his associates of the Surgical Research Department of the University of Pennsylvania. In a personal communication he cited their conclusions as follows:

a. The fall in blood pressure cannot be explained on the basis of a splanchnic paralysis alone.

b. The typical fall of spinal anesthesia is produced in animals with both splanchnics completely severed.

c. The entire vasomotor system participates in a vasodilatation and the degree of all is in direct ratio to the number of white rami anesthetized.

d. The fall in blood pressure may be greatly ameliorated by the vasoconstrictor effect of preliminary medication with ephedrin.

BENEFITS TO PATIENT

Convalescence after general anesthesia is frequently delayed two or three days, a period of great anxiety and trial to the patient, relatives and surgeon. It is a constant relief to us in making rounds not to see patients with the whipped dog, sea-sick appearance so often associated with ether. I do not mean to have you infer that we have no complications and no postoperative deaths, but we sincerely believe that the in-

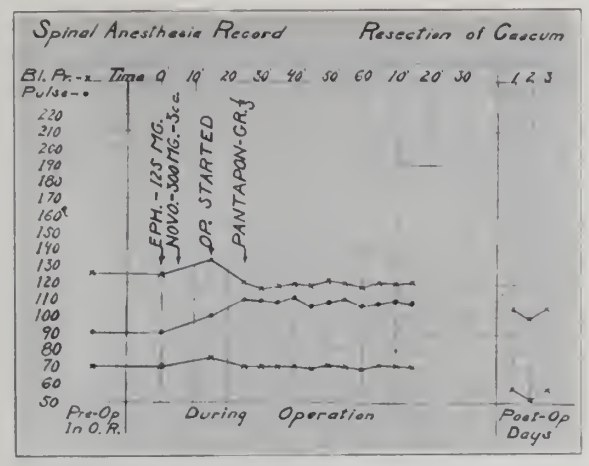

Fig. 3. A similar chart in a case of resection of cecum and ascending colon for carcinoma.

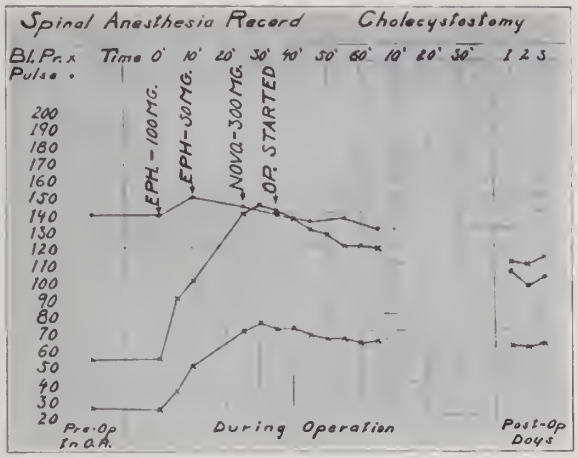

Fig. 4. Marked hypotension, 55/25. Patient admitted in very critical condition. Acute perforated cholecystitis with peritonitis. 100 mgs. ephedrin given, blood pressure rose to 145/75. Then cholecystostomy was done and drainage established.

cidence of complications and death has been reduced approximately 50 per cent according to our present tabulation.

What benefit is conferred upon the relatives and friends of the patient? This, when the patient returns from the operating room he usually greets them with a smile and a chuckle.

The atmosphere of the sickroom is changed from one which everyone hovers about with anxious, drawn faces to one of optimism and hope. The psychology of this mental uplift and support is strikingly beneficial. Pride is boosted, having gone through the ordeal without a moan, many of them never even complain during convalescence.

In a few words then, the advantages conferred upon the patient by spinal anesthesia are:

1. Freedom from mental perturbation over loss of consciousness.
2. Abolition of pain.
3. Appreciably shortens the time of operation.
4. Avoidance of many postoperative discomforts.
5. Diminishes the chances of complications.
6. Conserves strength in the nervous system.
7. Avoids disturbed function in or irritation of respiratory, secretory, assimilative, and excretory systems.
8. Limits mal effects to as few cells as possible.
9. Convalescence begins during operation and as a rule continues smoothly.
10. The patient is able to take fluids and food before, during and immediately after operation as indicated.
11. Is able to literally rejoice with relatives after the operation and witness the load of anxiety lifted from their faces.

BENEFITS TO SURGEON

Finally, what are the benefits conferred by this method upon the surgeon?

1. Greatly increased facility of operative technic due to complete muscular relaxation. The actual time of many operations is materially shortened.

2. Avoidance of use of a great number of pads.

3. The wound is maintained in a wide open condition by very light retraction.

4. Closure of abdominal wounds in a completely relaxed condition is more accurately and quickly done.

5. Multiple operations are undertaken with greater justification due to diminished trauma and increased facility of performance with consequent shortening of operative time.

6. The surgeon is relieved of a great deal of worry and anxiety over the condition of the patient, devoting his entire attention to the technical procedure.

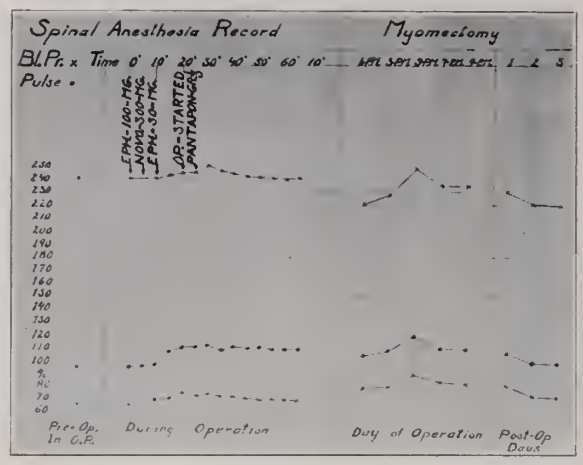

Fig. 5. Hypertension. Blood pressure 240/65. In this type of case, where we expect a marked blood pressure drop would attend spinal anesthesia, it can in our experience be obviated by giving larger doses of ephedrin. In this case, 100 mgs. were given 5 minutes before spinal and 50 mgs. 5 minutes after the spinal.

7. In cases of acute intestinal obstruction the point of obstruction is frequently actually seen in a moment instead of blindly hunting for it with the hand in squirming coils of distended intestines.

8. In acute inflammatory lesions of the abdomen, perforated gastric or duodenal ulcer, gangrenous cholecystitis, ruptured appendicitis with spreading peritonitis, it is a great deal like opening a colored anatomical atlas.

9. At times it permits a very essential cooperation between the patient and surgeon.

10. Team work is greatly increased in facility and satisfaction.

11. The reports from the nursing staff are remarkably uniform in expressions of favorable opinion of this method due to the practical abolition of vomiting, mental depression and the lessened incidence of complications insuring a smoother convalescence.

There are many other advantages, some of which will be apparent in the film.

I was rather reluctant to present this paper, being fully conscious of the fact that many in the audience are not sympathetic towards spinal anesthesia; however, I am not trying to sell it to them. My principal object is to present my impressions gathered through personal experience for the possible benefit of those who are using it or who would like to if they could be reassured as to its relative safety, efficacy, and manifold advantages. Undoubtedly there are exceptions to its use, and unquestionably it is dangerous if not properly administered. But I have lived too long in a surgical atmosphere not to realize that the active surgeon has not one but several swords suspended over his neck every minute of his waking hours and often in his dreams. As regards anesthesia, I have come to look upon the sword of general anesthesia as dull, ragged-edged and rusty; one which kills by slow degrees through its delayed infective complications, whereas, the sword of spinal anesthesia is keen-edged, bright, aseptic. One which, if it falls during the operation, may possibly be final in its action, but is no longer a menace once the operation is completed.

In my observation, those who object to spinal anesthesia fall into two groups:

1. Those who, while never having used it, are yet most vociferous in their condemnation; thus, typifying a common human frailty of uttering dogmatic opinions based on unwarranted prejudice with the voice of assumed authority.

2. Those who have used it incorrectly. The secret of satisfactory, safe spinal anesthesia, I believe, lies in the proper interlocking effect of the several agents used.

In one large hospital 75 per cent of the patients under spinal anesthesia had nausea and vomiting while on the operating table, others had alarming postoperative symptoms. Inquiry revealed that the largest dose of ephedrin used was 50 milligrams. Preoperative administration of sodium barbital and scopolamin was not used, only a preoperative hypodermic injection of morphine was given. Finally, no determined effort was made to prevent the loss of spinal fluid, nor were sterile gloves used in the administration. Altogether an absolutely unfair test of spinal anesthesia in the light of our own experience.

During my professional life I have endeavored to be conservative, slow to take to new methods until their worth was demonstrated by authorities, those things which I have tried and found good I have held on to. I cannot but feel, as I look back over many years of operative work under general anesthesia, that today under spinal anesthesia I

Fig. 6.

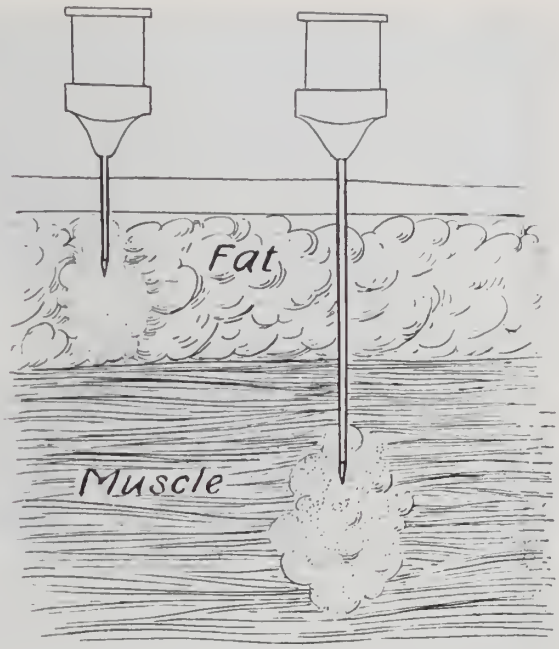

Fig. 7.

am rendering better technical surgical service to my patients and saving more lives than formerly through the avoidance of complications.

REMARKS DURING SHOWING OF FILM

There are, then, three levels of anesthesia which we routinely obtain:

1. To the level of iliac crests—for work on lower extremities, perineum, rectum, hernia operations, etc.
2. To the level of costal margin.
3. To the level of clavicle.

This next animated diagram shows the vasodilator effect of spinal anesthesia. As noted by Ravden, this is general and not limited to the splanchnic area, and can be largely prevented by ephedrin.

Preparation of patient for spinal anesthesia: 1½ hours previously patient has taken by mouth ten (10) grains of sodium barbital; ½ hour later one-one hundred and fiftieth (1/150) scopolamin, (reduced to one-three hundredth (1/300) in elderly frail patients) and one-third (1/3) grains of pantopon, given together.

The next step and one which I consider absolutely essential is the injection of ephedrin into the back muscles (Fig. No. 6) with a rather long needle, to insure its passing through the fat and into the muscle. (Fig. No. 7) Note that spinal anesthetist's table has everything essential within reach. (Fig. No. 8).

The spinal needle is then tested and passed until it encounters fluid. This, as noted in the animated diagram, is accompanied by a characteristic sensation as the needle penetrates the membrane.

The desired amount of spinal fluid is withdrawn, the obturator immediately placed in the needle to prevent the loss of any spinal fluid, which in our experience obviates headaches. The injection of the mixture of novocain and spinal fluid is not permissible until five full minutes by the clock have passed since the ephedrin injection.

The injection is made at the rate of 5 seconds for each cubic centimeter of spinal fluid. You will note that at the end of the aspiration of spinal fluid, a small amount was reinjected to insure that the needle end was still in position and also that at the end of injection, a small amount was reaspirated to reinsure that the needle point had not changed position. Once the novocain is properly deposited, 100 per cent anesthesia results.

The patient is kept in the horizontal position for 10 minutes; in our experience, this is the time it takes for complete chemotaxis between the novocain and nerve tissues. The level of anesthesia cannot be changed after this time by changing the position of the patient. In Fig. 9 the localizing effect on one lower extremity is seen.

That this is true, may be noted in amputation of the lower extremity. Immediately after the injection the patient was turned on his side and kept so for 10 minutes.

As you can see, he gets off the operating table unassisted by using the unanesthetized limb in a normal way.

This localizing fixation can also be nicely demonstrated in nephrectomies.

For all operations on the lower extremities, it produces an anesthesia par excellence.

Here, brother Jim is doing an open reduction for a fractured tibia using the radio knife, coagulating current and his special bone clamp permitting a perfect approximation. No finger enters the wound and no ligating material is used.

Fig. 8.

In fractures of the hip, especially in the aged, this method is a godsend. In two instances of dislocation of the hip the reduction was automatic, occurring before a hand could be used in manipulation.

In rectal operation for hemorrhoids, or dissecting out fistulous tracts, perineal and vaginal operation, anesthesia to the level of the iliac crests is very satisfactory.

KRASKE OPERATION

I believe many surgeons have been converted to spinal anesthesia after once using it in Kraske operations. Most assuredly, any general anesthesia in these cases should be condemned. I recently saw a patient die of shock on the operating table in a New York hospital while undergoing this operation under ether. Such things cannot happen under spinal anesthesia, as all nerve impulses are abolished, whereas under ether, I am sure there is a continuous and devastating bombardment of the nervous system throughout the operation from trauma in the field.

ALBEE BONE GRAFT

Brother Jim uses spinal anesthesia in Albee bone graft patients with entire satisfaction; especially if there is any suggestion of pulmonary tuberculosis, would this method seem preferable.

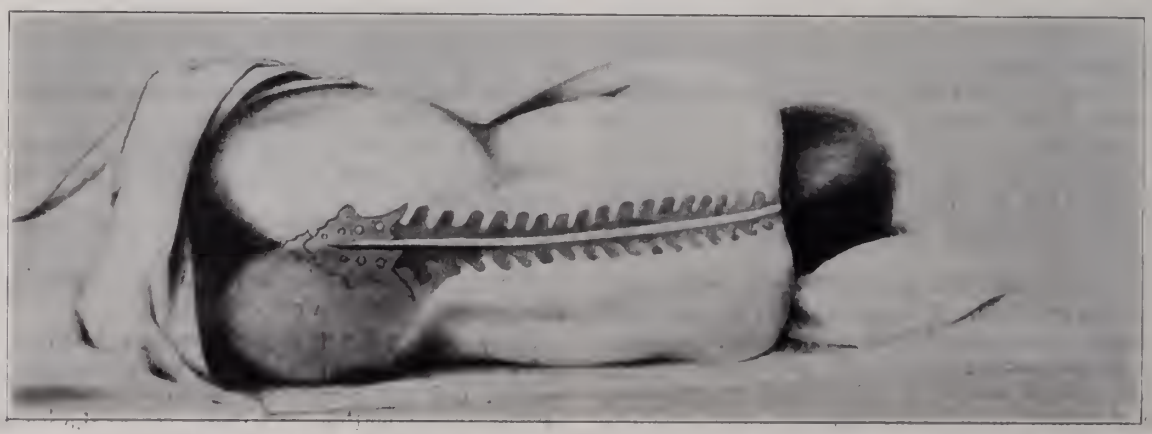

Fig. 9.

Fig. 10.

Fig. 12.

LAPAROTOMIES

In laparotomies, as in this young woman with a solid ovarian tumor, the complete relaxation, the contracted intestine, doing away with the use of many pads, provides a condition which approaches a surgical paradise. (Fig. No. 10) This also applies in cholecystectomy.

RESECTIONS OF THE COLON

In resections of any part of the colon for carcinoma, this method permits of and indeed encourages, more thorough, more technically perfect operative procedures than any other.

This patient had a huge carcinoma of the splenic flexure. It was easily mobilized and resected, using the DePetz clamp with silver staple sewing machine effect.

Making rounds the next morning, where is the shock, the depression, the anxious, semi-intoxicated faces seen after ether? Gone, all gone.

Resection of the cecum and ascending colon in a frail woman aged 68. The next morning she fairly exudes psychic uplift for herself and relatives.

These are not selected cases. They are the routine run of the mill in hospitals where spinal anesthesia is properly used.

Is it contraindicated in infancy? No! Little children, as this one, aged 4, brought in with acute gangrenous, perforated appendicitis with distended, painful belly, immediately cease crying after the spinal and contentedly suck a lolly pop during the operation. Already in desperate condition the added blow of a general anesthesia is often too much for them.

Fig. 11.

In splenectomies, this method greatly facilitates mobilization and removal of the organ. We have also found it of great aid in the repair of diaphragmatic hernia.

In gastric resections for ulcer and carcinoma it permits more generous access to and mobilization of the stomach and its lympathic drainage area, factors which permit and invite a far more perfect technical procedure.

In extensive and difficult resections I have found that the use of the DePetz clamp and silver staples (Fig. No. 11) save about 20 minutes in time which permits of completing the operation before the anesthesia wears off as sometimes occurred before making use of it. I have used it now in some 20 gastrectomies and consider it an invaluable aid.

Is age a contraindication? No! This frail old man of 84 with a chronic duodenal ulcer causing obstruction, is having a gastro-enterostomy made which gave him complete relief.

A supreme test as to the safety, efficacy and advantages or disadvantages of an anesthetic ought to be apparent in a resection of the left lobe of the liver in a woman aged 80 for primary carcinoma. An exploratory operation for possible pancreatic cyst revealed this condition. The left lobe of the liver was resected with clamp and cautery. (Fig. No. 12) There was no shock during or after the operation. Convalescence was uneventful. Patient was discharged on the seventeenth postoperative day and today—15 months later—is well and doing her own housework.

DIGEST OF POOR RELIEF LAWS

A digest of poor relief laws designed to inform the members on how authorization is secured for medical and surgical care of the indigent has been published by the State Society. Because of the fact that Milwaukee County has separate county institutions, the digest is not applicable in practice in Milwaukee County. Additional copies may be procured without cost that they may be placed in the hands of local poor relief authorities.

Two Years Experience With Spinal Anesthesia*

By F. E. BUTLER, M. D.
Menomonie

Some one said that only those observers who are enthusiastic about new methods write about them, and that enthusiastic persons are proverbially given to unconscious exaggeration. Be that as it may, it is difficult to use spinal anesthesia and not become enthusiastic. The method may more properly be termed a nerve root than a spinal anesthesia, since it is the sensory nerve roots as they meet the spinal cord rather than the spinal cord itself which is anesthetized.

In reading the voluminous literature on spinal anesthesia, one wonders at the fact that some of the leading surgeons of the country are enthusiastic about it, while others of equal prominence, although in the minority, condemn it. By far the majority of surgeons using spinal anesthesia use it only in bad risk cases such as diabetes, respiratory infections, intestinal obstructions, and all conditions in which a general anesthetic is contraindicated.

In approaching this subject of safety, one must consider primarily the best interests of the patient, all other considerations being of secondary importance,—matters of economy, difficulty of acquiring the necessary technic, the problem of educating the laity, prejudice, and many other more or less objectionable factors. The patient's safety is without question the most important factor in every case, and therefore it would seem that his welfare should take precedence over all these. Heretofore, spinal anesthesia was undoubtedly one of the most dangerous. Now, however, one reads reports of from 5 to 10,000 cases by one man without a fatality. There is an opportunity for an honest difference of opinion in regard to the factor of safety. So far as immediate mortality is concerned, it may be true that spinal is more dangerous than general anesthesia. However, if one takes into consideration the remote complications of general anesthesia, I believe the balance is in favor of spinal, provided one adheres to a rigid routine and has an experienced psycho-anesthetist.

The proponents of spinal anesthesia believe that, on account of the lessened trauma to the intestines, stomach, etc., made possible by the silent abdomen, dangerous postoperative complications are less liable to occur; so in reflecting upon this subject of safety, there are, therefore, many phases to be considered. No other anesthesia can present the so-called silent field with the degree of perfection possible under spinal anesthesia. The absence of forced respiration, the flaccidity of the muscles whose reflexes are completely abolished, the negative pressure present when the abdomen is opened, offers an opportunity to observe the tissues and to carry out operative procedures under conditions that are almost ideal. Rarely is it necessary to introduce gauze packs for the removal of the intestines from the pelvis in gynecological surgery. I have often thought that, if for no other reason than the ease of closing a long abdominal incision in an obese patient, spinal anesthesia was well worth the effort.

In the smaller hospitals and communities, there are not the expert anesthetists found in the large cities, and if the surgeon can give his own anesthetic in 80% of his operations with safety to his patients and satisfaction to himself, he is very likely to become an advocate of that form of anesthesia.

Several years ago we began using spinal anesthesia on the bad risk patients as advocated by so many. A typical attitude of those using it only in bad risk cases is quoted from a writer several months ago who says, "I do not believe that the ordinary run of operations of the upper abdomen on good risk patients can be done with a greater degree of safety under spinal anesthesia than with ether or gas—local combination. However, if the patient is a poor risk because of associated damage to the heart, lungs or kidneys, or if the patient is diabetic, the safer method is spinal anesthesia." This attitude I think is wrong, and we soon decided that

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if it was good for the bad risk, certainly it could not be harmful to the average or good risk patient. And in the past two years we have not given a general anesthetic for any operation below the diaphragm, provided the patient was over five or six years of age. While we have used it on younger patients, our chief objection is the difficulty of controlling them during the injection. In two cases, after attempting it, it was necessary to give a general anesthetic long enough to complete the injection, after which the operation was completed under ideal spinal anesthesia.

STOUT'S TECHNIC

We have used it in 412 cases, ranging in age from 3 to 83 years without a death that could in any way be attributed to the anesthetic; using from one to three hundred milligrams (rarely four hundred) of novocaine, by Stout's volume control technic,—the injection being given at the third or fourth lumbar interspace. We have never found it necessary to give the higher injections with its attendant danger of injuring the spinal cord. While it has not always been possible to estimate the exact height of the anesthesia, on the whole it has been quite satisfactory. And one must be sure that the amount of spinal fluid withdrawn, the loss of fluid, the rate of injection, position of the table, etc., are correct before criticising volume control. It is not unusual to see an anesthetist withdraw what he estimates to be 3 or 4 c.c. of spinal fluid, then allow another c.c. or two to escape before returning the stylet in the needle; then, while giving orders to a nurse, inject the solution, paying no attention to the rate of injection. This is not volume control technic. And if the surgeon who gives his own anesthetic will consider that the operation actually begins with the injection, and gives it the same attention to details that he does to other parts of the operation, there will be fewer critics of the method.

The anesthetist should also bear in mind that the induction of anesthesia is begun at the time that the patient's apprehension is most likely to have reached the peak, and should be given with the minimum amount of discomfort. If the details of the preoperative management have been carefully carried out, with the assistance of a tactful nurse this is usually not much of a problem. The chief complaint of my patients of the anesthetic has been the pain caused by the spinal needle, and it is for this reason that I now always inject a one per cent (1%) novocaine solution into the skin and interspace. Several drugs and combinations have been tried to control the patient's natural dread of an operation and at the same time to insure his cooperation. The type of anesthesia is never discussed with the patient,—if asked concerning the method to be used, the patient is given to understand that this detail, like all others connected with the operation, should be left to the surgeon; and if he is willing to place himself in the hands of the surgeon for the performance of an operation, he ought to be willing to allow him to use his judgment regarding this point.

The patient is insured a night's sleep; one and a half hour before the operation he is given ten (10) grains of sodium barbital; one hour later, one-third (1/3) gr. of pantopon and one-one hundred and fiftieth (1/150) gr. of scopolamine. Technically, the method of administration is fairly easy and has been adequately and frequently described, and a repetition here is unnecessary. Besides, each anesthetist is already convinced of the superiority of his own technic and its adaptability to his own particular problems. The proper position of the patient, with maximum bowing of the vertebrae, and the shoulders being perpendicular are the two most important points. The upper shoulder always has a tendency to advance in front of the lower, causing a twisting of the spine. The difficulties of doing a spinal puncture on a large, obese patient has always seemed to me to be more mental than real. The rate of injection is probably one of the most important factors in determining the height of the anesthesia,—at least, lack of attention to it is one of the most common errors.

Failure to secure anesthesia is always due to an error of technic; in other words, a properly given spinal is always successful, the only limitation being the matter of time,—however, one is practically always assured one hour of complete relaxation. In

four of our cases it was necessary to complete the operation under ether. At the least sign of returning sensation, we believe it better practice to immediately begin general anesthesia than to try to control the patient by morphine or the so-called vocal anesthesia. This is often quite embarrassing and difficult to explain to the patient, so, in the past eighteen months, in operations liable to last over an hour, we have been using nupercaine. This is a quinoline derivative supplied in a two (2) c.c. ampule of buffered solution, containing ten (10) milligrams of nupercaine (a 1/200 mixture). The technic is the same as for novocaine, using part or all of the ampule, depending on the dose required. Contrary to novocaine, the nupercaine solution is of lighter specific gravity than the spinal fluid, and the patient must immediately be put in Trendelburg position, the degree of tilt depending upon the height of anesthesia required. Anesthesia lasts from three to six hours. The effect on the patient is the same as novocaine except that the drop in blood pressure usually comes earlier. It has been used in 37 operations and has been very satisfactory. We use it almost routinely in fractures of the femur. Even up to forty-eight hours after the fracture, it is possible with a Steinman pin and sufficient weight to separate the ends of an overriding fracture, before the anesthesia has worn off.

Keyes has called attention to spinal anesthesia as a method of relieving renal colic. We used nupercaine in 3 cases with good results, getting absolute relief of pain in 5 minutes. In one case, the stone was passed at the fifth hour with return of sensation at the sixth. It has also been used in several cases of intractable sciatica when nothing but morphine would relieve.

An often forgotten use of spinal anesthesia is in patients after an abdominal operation that gives evidence of possible intestinal obstruction. Spinal anesthesia practically always gives the answer. If, within 20 minutes, there is no passage of feces or flatus, one may be quite sure he is dealing with an obstruction, and as the patient is anesthetized, can promptly reopen the incision and make a manual examination.

COMPLICATIONS

The two great dreads, the fall in blood pressure and the danger of respiratory paralysis, are the cause of a great deal of controversy. There are those who believe that a fall in blood pressure, no matter to what extent, can result in no harm if cerebral anemia is prevented by an adequate Trendelenburg position. Others feel that a fall in blood pressure to any great extent is a sign of severe circulatory or vascular depression, leading to true shock. Those who believe that a fall in blood pressure is a serious matter, prevent it or treat it with ephedrine; the other school simply place the patient in the Trendelenburg position and pay no attention to blood pressure, the cause of the fall being due to pooling of blood in the splanchnic vessels as a result of the paralysis of the vasoconstricting fibers, coming from the smypathetic ganglia, caused by the action of the drug on the anterior roots. At first, we would become very apprehensive when the blood pressure dropped to 90 and would give more ephedrine or adrenalin. Now, however, after the initial dose of ephedrine, given five minutes before the spinal puncture, we have treated all cases by the Trendelenburg position alone.

At the first sign of nausea or respiratory embarrassment, one must determine whether it is psychic, due to traction on the mesentery or viscera, or low blood pressure. Deep breathing and diverting the patient's mind will relieve the psychic cases, while the Trendelenburg position is all that is necessary in the low blood pressure cases.

The fear of respiratory paralysis would seem to be exaggerated, especially since Koster's work, who does operations on the head under spinal anesthesia. The literature shows that it has been a rare complication, and is associated with errors in technic or overdosage. However, most surgeons will be satisfied to confine their surgery below the diaphragm.

Following operation, the most frequent complication has been headache. The patients usually complain of occipital pain, appearing 24 hours after operation. This is worse when the head and shoulders are raised and relieved when the head is lowered

again. The pain is thought to be due to continual loss of spinal fluid through the lumbar puncture wound. This condition is rather intractable to any form of treatment and may last several days or a week. Recently it has been reported that a retention enema of 6 ounces of 50% magnesium sulphate solution gives relief. Falk reports having largely overcome the incidence of headaches by boiling the syringe and needles in distilled water instead of tap water. However, time is the essential factor in the ultimate result. Headaches have occurred in about 10% of our cases. We have had two cases of pneumonia, both in ruptured appendices with an acute respiratory infection of such a degree as to positively contra-indicate general anesthesia. Both patients recovered. One patient developed a severe phlebitis following a double herniotomy. He had a blood pressure of 180, and had a severe drop in blood pressure during the operation. We have had none of the ocular palsies reported by others.

In some cases, spinal anesthesia is the only type of anesthesia to be employed; in many cases it is the best type of anesthesia; and in all cases where it is indicated it can be made safe.

In beginning the use of the spinal anesthesia, I believe one should confine it to the robust good risk, instead of the poor risk patient and to operations below the umbilicus. As one's experience grows, he can do all his surgery below the diaphragm,—and as his skill in administering it increases, so will his appreciation of its advantages grow.

Epilepsy in Children*

By M. G. PETERMAN, M. D.
Milwaukee

In the past ten years there has been a renewed interest in the United States in epilepsy of childhood. The interest was stimulated by the report of a new form of treatment, the ketogenic or high fat diet. (1) My reports of results in the treatment of children with this special diet have been followd by many others. (2) Epilepsy and the convulsive disorders are now receiving considerable attention from the standpoint, not only of treatment, but of causation or etiology. (3)

There is an effort on the part of the neurologists to consider epilepsy a symptom rather than a disease entity, and to place this disorder among the larger group of the convulsive states. It is my opinion that idiopathic or essential epilepsy is a disease entity, a chronic disease of the nervous system characterized by periodically recurring convulsions, lapses, or abnormal mental states occurring in an individual with a constitutional inferiority or personality defect, some inherited nervous system defect, which we are at present unable to demonstrate pathologically, but which renders this individual a potential subject of the convulsive disorder. In my study of convulsions in children (4) I am convinced that the idiopathic epilepsies form a separate and distinct group. Before the disease has progressed, these children are usually mentally precocious, alert, sensitive, and temperamental. It would seem that they are born potential epileptics but require a metabolic disturbance to precipitate the convulsions. The attacks do not begin until a certain time, usually before puberty, and then they become progressive in frequency and severity.

If there is a "convulsive state" is occurs early, usually children under five are the most susceptible to convulsions. At this age the onset of acute infections, digestive upsets, and dysregulation of the water metabolism are often associated with the convulsions. The immediate precipitating factor is usually a cerebral edema. Epilepsy, as a rule, appears later. The most common convulsive disorder in childhood is spasmophilia or tetany. Only 5% of the spasmophiliacs develop epilepsy and the epileptics usually do not show a history of previous spas-

* From the Milwaukee Children's Hospital and the Department of Pediatrics Marquette University School of Medicine. Presented before 90th Anniversary Meeting, State Medical Socity of Wisconsin, Madison, Sept., 1931.

mophilia. (4) The epileptic child, exposed as are all children, to the disturbances mentioned does not have convulsions until his disease cycle has begun. Non-epileptics, on the other hand, subject to convulsions in infancy and childhood, do not develop epilepsy even though subjected to the same stimuli. Only 5 to 7% of the epileptics give a history of infantile convulsions or a susceptibility to convulsive disorders in this earlier period. Thus far we have been unable to demonstrate any consistent physical abnormality in the epileptic between attacks, in his nervous system, brain and spinal cord; sympathetic-autonomic system; gastro-intestinal tract; circulatory system; endocrine glands; basal metabolism; physicochemical equilibrium of nerve cells; acid base regulation; mineral metabolism; blood, urine, spinal fluid; carbohydrate, protein, and fat metabolism; and at post mortem examination. Indeed, when we find evidence of a physical abnormality, we may consider the convulsions on another basis.

The diagnosis of idopathic epilepsy is made by exclusion. Occasionally an erroneous diagnosis of idiopathic epilepsy will be made when a cerebral lesion presents no symptoms or signs other than recurring convulsions. A careful history and encephalograms will usually establish the diagnosis in these cases. While we have been able to classify and explain most of the convulsions of infancy and childhood, the etiology of epilepsy remains an enigma.

ADVANCE IN TREATMENT

Little progress has been made in the study of the etiology of the disease. Much greater advance has been made in the methods of treatment. Starvation remains the most effective means of controlling grand and petit mal seizures. Much as we know of the physiologic changes which take place in starvation, we do not know why these changes influence the convulsions. The ketogenic diet was proposed as a means of reproducing the ketosis, tendency to acidosis, depletion of carbohydrate reserve of the body of starvation, providing, however, adequate nutrition. This diet consists of 15 grams of carbohydrate, 1 gm. of protein per kilo (2 gm. in children under 5 years) with the remaining calories supplied in fat to provide 130% to 150% of the basal metabolic requirement. The vitamines, especially B, and the minerals, particularly calcium, must be provided. These factors were emphasized in my earliest publications. (1) Brewer's yeast concentrate is now added to the diet in 1 gm. daily doses to insure an adequate supply of vitamine B. Calcium lactate is given in doses of 1 gm. daily. The fat is further increased if necessary to keep the desired body weight or to control the seizures. Within six months after control of seizures the protein and then the carbohydrate are gradually increased.

Shortly after the diet was introduced I demonstrated that its effectiveness was not due to the ketosis or to the tendency to acidosis produced. (1925) (1) McQuarrie and Keith in 1927 felt that the degree of ketosis was a factor in the control of seizures, but in 1929 they agreed "that the concentration of acetone bodies in the blood bears little relationship to the prevention of seizures apart from their acid effect as shown in this experiment." (5) These investigators also confirmed my observations of the failure of non-ketogenic acid ash foods to control seizures. They used carbohydrate free, low and high protein diets.

A ketosis produced by feeding large amounts of sodium bicarbonate with a moderate restriction of carbohydrate and protein I found to increase the convulsions of epilepsy. In five children with petit mal, under control on the ketogenic diet, I was unable, however, to produce a recurrence of seizures with soda bicarbonate in amounts sufficient to alkalinize the urine (10–15 gm. daily for one week). Lennox produced a recurrence of seizures in one case with 25 gm. of sodium bicarbonate daily in a patient who was under control on the ketogenic diet. (3) McQuarrie and Keith (6) reported an increase in the seizures of one patient under control with the ketogenic diet following the administration of 10 to 15 gm. of Na HCO_3. Three other patients, however, remained free. An acidosis to the extent of a urine pH of 5.4 and a depletion of the alkali reserve to 20 volumes per cent, which I pro-

duced with ammonium chloride and continued over 30 days, had no consistent effect on convulsions when fluids and the diet were not restricted. Lennox (3) has obtained marked temporary reduction in the frequency of seizures with NH_4 Cl, Ca Cl_2, and NH_4 NO_3. Continued use of the salts a week or more, however, resulted in a recurrence and an increase in the number of seizures.

In four patients I substituted half of the fat in the diet with intarvin, an odd carbon atom fat. The ketone bodies disappeared from the urine, but there was no return of the seizures. However, 50 gms. or more of carbohydrate, added to the diet suddenly, would usually be followed by a number of seizures.

In 1926 Elsberg and Pike emphasized the importance of cerebral edema as a cause of convulsions. (7) They suggested that possibly the effectiveness of starvation in epilepsy might be due in part to the dehydration produced. In 1928 Fay proposed the mechanical theory of epilepsy (8), elaborating upon Dandy's theory (9), also calling attention to cerebral edema in convulsions. Possibly the thickened pia, the subpial collections of fluid, and the atrophy which Dandy and Fay describe in epileptics, are the result rather than the cause of the convulsions. Fay, 1928, suggested the dehydration factor as a possible explanation of the effect of the ketogenic diet. McQuarrie in 1929 demonstrated the dehydration effect of the ketogenic diet. He showed the effect of water balance on seizures and suggested that "Brain 'wetness' might be due to a long existing unbalance between the factors referred to and not necessarily the primary condition." Beginning in 1928, following the suggestion of Elsberg and Pike, we have observed that the weight loss in starvation and on the ketogenic diet was due to the loss of water. This was further substantiated by the dry skin, and the increased disappearance time of the wheal from one hour to five or ten minutes. The extent of dehydration varies with different children and is influenced by the water intake and excretion, the body temperature, external temperature and humidity, and the activity.

In 1928 I reported twenty patients kept free of seizures with the ketogenic diet for 12 to 36 months after which they had been returned to a normal diet and had remained free of seizures. (10) Two of these reported cases (both petit mal) have had a recurrence following over-indulgence in foods, especially carbohydrate. These patients had been free 12 and 15 months after a return to the normal diet, but it was later learned that while free and on the ketogenic diet they had been indulging in extra carbohydrate, gradually increasing the amounts as they continued. Both patients can now be kept free of seizures on the ketogenic diet, but they have lost their morale and frequently break diet with the expected results.

NEW SERIES

Since the last report I have studied 110 additional cases of idiopathic epilepsy. This series is not large but it represents a personal study of a group of children under close observation. There were 57 boys of whom 34 had grand mal, 9 petit mal and 14 grand and petit mal; 53 girls of whom 27 had grand mal, 14 petit mal and 12, both. Nineteen cases of petit mal developed grand mal, and 4 cases of grand mal developed petit mal. The ages of this group of patients ranged from 15½ months to 15 years and the duration of seizures from 6 months to 11 years. In 27 patients, a history was obtained of epilepsy or convulsions in the immediate blood relatives; in 16 additional there was a history of migraine, extreme nervousness, diabetes or hay fever; in 21 patients an accurate family history could not be obtained, and in 47 it was given as negative.

The physical examinations, including careful neurologic and fundus examinations were essentially negative in all 111 patients. The erythrocyte, hemoglobin, leucocyte, and differential counts, and the spinal fluid examinations were within normal limits in all. Urinalyses and stool examinations were negative in all. Roentgenograms of the skull were taken in 63 cases and were found normal. The mental age and intelligence quotient were not determined in any case. However, an estimate of the mentality was made after observation of the patient for 2 to 5 weeks in the hospital followed by monthly

or semi-annual returns. This estimate was compared with the school progress of the child and the result noted as above normal, normal, and subnormal. Fifty-one patients rated well above normal, 38 normal, 14 below normal, and 8 definitely subnormal.

This series includes four patients with a history of preconvulsive attacks of epilepsy. One boy 8 years old gave a 6 months' history of periodically recurring attacks of gastro-intestinal upsets. At regular intervals once a month between 5 and 6 A. M. the boy would get up in a confused state, rush to the bathroom and attempt to vomit. The attempts were usually unsuccessful, after several minutes the child was put back to bed and he slept for several hours. He always complained of vertigo at the time. The child had no recollection of the events. He was constipated before the attacks. After six months of stereotyped attacks there was at the next interval a grand mal convulsion. A daily regimen as described below and phenobarbital were given. The patient has been free of seizures 2 years.

A girl 6 years old awoke with a cry at 9 P. M. after 2 hours of sleep. She was disoriented and trembled all over. She cried with fright, could not be awakened or reassured; then after half an hour fell into a deep sleep. Three attacks occurred at six week intervals at the same time in the evening. All three were associated with constipation and were preceded by overindulgence in food. Three grand mal convulsions followed the three preconvulsive attacks occurring with striking regularity at the same time in the night. This patient has remained free of all seizures on the ketogenic diet plus fluid restriction.

Two other patients had periodically recurring night terrors preceding attacks of grand mal. Both are free on a daily regimen and phenobarbital.

TREATMENT

The treatment in this series of cases was determined by the social, economic, and other factors which obtained. All patients received a spinal fluid drainage mainly as a diagnostic procedure.

Five patients did not stay for complete treatment and were lost from observation. One child with grand mal was fitted with glasses and put on a definite daily regimen. This consists of a well balanced, well prepared, anticonstipation diet supplied in three regular meals a day; rest before and after meals, a nap at noon and 10 to 12 hours sleep at night; a saline cathartic whenever necessary to insure a daily bowel movement; a restriction of mental and physical activity to avoid over exertion. This patient has remained free of seizures over one year.

Thirty-four children were put on the above regimen plus phenobarbital in sufficient dosage to either control seizures or until undesirable drug reactions were produced. Sixteen patients, 47%, with grand mal have been free of seizures for 6 months to 3 years; 7 patients show considerable improvement: 4 patients show no improvement; and 6 patients are lost from observation. These results are considered good. In a previous series I obtained only 35% free of seizures with the above treatment. However, this group includes a number of patients in the early stage with few convulsions.

Fifty-one selected patients, 21 with petit mal, 14 grand mal, and 16 with both petit and grand mal were treated with the ketogenic diet. In 7 patients the fluid intake exclusive of the diet were restricted to 300 to 600 c.c. Twenty patients, 39%, have been free of seizures for 6 months to 3½ years. Seven more patients remain entirely free while on this diet; periodically, however, they break diet with a resulting precipitation of seizures. Those patients have remained free for 6 to 24 months. Fifteen patients, 36%, show considerable improvement with a reduction in frequency and severity of seizures; nine patients have showed no improvement.

Thirteen patients were given a diet in which the carbohydrate was moderately restricted and the fat moderately increased. The food was not weighed. Enough was allowed to satisfy the appetite. The intake approximated 85 to 90 calories per kilo with a ratio of CHO 2, Protein 1, Fat 4 (1.5 to 2 grams of protein per kilo). This provides a G:FA ratio of 1:1.5. The liquid intake was restricted to 300 to 800 c.c. daily. Seven pa-

tients have been free of seizures for 6 to 12 months, four are improved, and two are not under control.

Six patients were given the above restricted diet plus fluid restriction and phenobarbital in addition. Of these, three are free of seizures, one has fewer seizures, one has more, and one is not improved.

Seven patients were given sodium salicylate* in an effort to produce an acidosis or an effect on the epileptic seizures. Hurtley and Trevan suggested that salicylic acid might produce an acidosis condition similar to diabetic coma. (11) Johnson recently has demonstrated that the readily absorbable salicylates in full therapeutic doses produced a definite respiratory stimulation and a lowering of the alkali reserve. The result was considered the equivalent of a fixed base acidosis with the pH of the blood plasma unchanged and no acetonuria. (12) Five patients were improved on the ketogenic diet, but had occasional seizures. They were given sodium salicylate by mouth in doses of two to three grams daily for one to two months. In only one patient was there a decrease in the number of seizures with an increase when the salicylate was stopped. Two patients having daily seizures of grand mal were given two (2) grams of sodium salicylate daily by intravenous injection. In one child there was a considerable diminution in the number of seizures with an increase when the injections were stopped. The other child showed no effect. These results are incomplete, but so far inconclusive.

CLINICAL OBSERVATIONS

A series of charts are submitted to illustrate the typical results of some of the above procedures. The ketogenic diet introduced after a preliminary fast of 6 to 10 days produces a ketosis, tendency to acidosis, depletion of the carbohydrate reserve, and a partial dehydration of the tissues. The ketone bodies usually appear in the blood, urine, and alveolar air during the fast and are markedly increased two to four days after the diet is begun. They may be increased to 40 times normal. The tendency to acidosis usually lowers the alkali reserve to the lower limits of normal, 40 vol. per cent, seldom below. The fasting blood sugar usually reaches the lower limits of normal, 60 to 80 mg. Under the ketosis the carbohydrate tolerance is decreased and continues diminished as long as 10 days after a return to the general diet. This is indicated by a low fasting blood sugar, a delayed rise in blood sugar after glucose, an abnormally high peak, and a delay in the return to normal.

The weight loss of 1 to 3 kilos is a water loss as indicated by the increased urinary output, the dry skin, and the shortened disappearance time of the wheal. (The time required for the disappearance of an intradermal wheal produced by the injection of 0.2 c.c. of normal saline is an indication of the water balance as well as the kidney function of the body. The normal disappearance time is 45 to 60 minutes.) Within 4 to 5 days after the ketogenic diet is instituted, barring extraneous factors, the disappearance time is decreased and continues to decrease to 5 minutes in 10 to 14 days. The disappearance time of the wheal is a rough indication of the extent of dehydration. With the onset of ketosis the nervous activity of the child is considerably diminished. The child becomes quiet, calm, and relaxed. In some cases the patellar reflexes have temporarily disappeared. Occasionally, children who do not eat all of the food complain of cramps in the muscles of the legs. While it may be possible with severe diet restriction to demonstrate a slightly negative calcium and nitrogen balance, my patients have usually made a normal growth and development. No increased blood pressure has developed in any case. Twelve patients showed no hypercholesteremia after a return to the normal diet; one patient showed a blood cholesterol of 328 mg. (per 100 c.c.) at the conclusion of four years on the diet, but presented a normal blood pressure and urine.

CONCLUSIONS

It seems desirable at present to retain the designation "epilepsy" to describe a certain disease complex of which the most characteristic symptom is periodically recurring convulsions. The convulsions are appar-

* The sodium salicylate was kindly supplied by Eli Lilly Co., Indianapolis, Indiana.

ently immediately due, as are most convulsions, to a cerebral edema. The cause of epilepsy and of the periodical recurrence of the convulsive state is not known. The most important problem in the study of a patient with convulsions is a differential diagnosis and the final diagnosis of epilepsy is made by exclusion.

The practical treatment of the epileptic child (if he cannot be placed in a hospital for fasting and the ketogenic diet) may be summarized as follows: 1. A definite daily regimen which includes a long nap and a long sleep, meals at regular hours and a daily bowel movement. 2. A restricted carbohydrate and protein and a high fat diet. 3. Fluid restriction to a minimum, at least to 600 or 800 c.c. daily and less if convulsions continue. 4. Phenobarbital in large enough doses to control any seizures which may occur after or until the above procedures are established.

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Skull Fractures*

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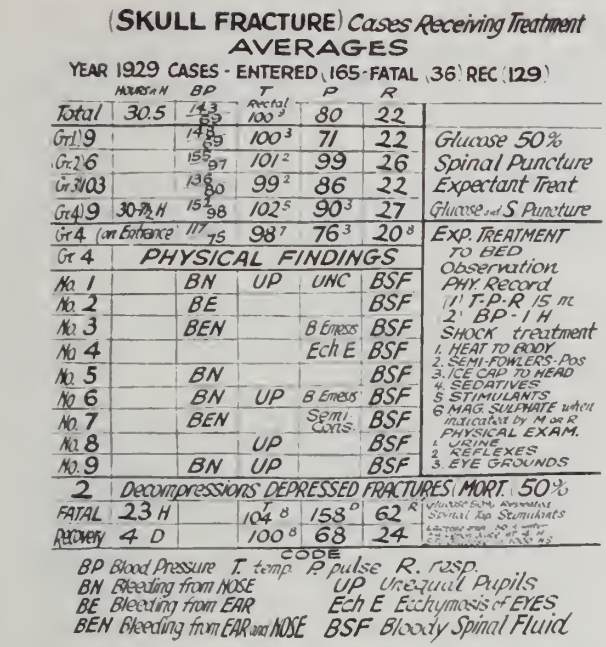
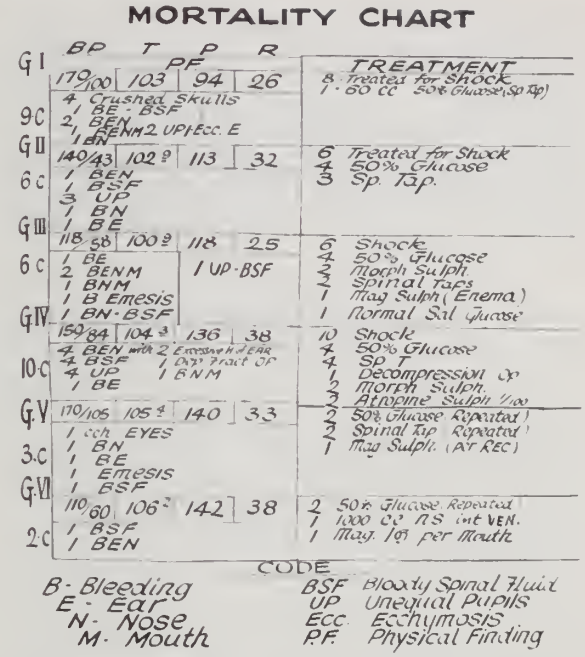
The problem of skull fractures, or, what would be more appropriately expressed as intracranial injuries, has been discussed repeatedly, but, until recently, very little progress has been made in providing uniform treatment.

The papers published in the last two years have been more uniform in the main points in treatment, and it is almost unanimously accepted that the conservative treatment of intracranial injuries is preferable to the more radical. In view of this fact, I felt it would be of interest and value to study a series of cases, rather minutely, as to pathology, clinical record, mortality and treatment. Therefore I chose a series of consecutive cases of the year 1929, rather than a more generalized survey of the six hundred cases treated at the Johnston Emergency Hospital in the last five years. This year would seem

* Presented before 90th Anniversary Meeting, State Medical Society of Wisconsin, Madison, Sept., 1931.





preferable, since there was more uniformity of treatment than in previous years. The pendulum has swung from the more radical treatment through a period of quiescence and uncertain stability to a more uniform acceptance of the important points in the treatment of skull fractures.

The diagrams I wish to present represent a statistical survey of 165 cases seen in one year. Of these, thirty-six died in the hospital. The remaining one hundred twenty-nine were discharged, and, in practically every case, placed under the care of private physicians in other institutions. The mortality rate for the year 1929 was twenty per cent, which was somewhat lower than in previous years. This rate has been maintained until the present time. The findings have been charted in order that a better understanding may be possible, and follow:

YEAR 1929 REPORT FATAL CASES (36)

FATALITIES	1-HOUR	1-3 H.	3-9 H	9-24 H	1-2 DAYS	2-4 Days	AV.
B.P.	170/100	140/43	118/58	151/92	170/105	110/60	143/76
Rectal Temp.	103	102.9	100.9	104.3	105.4	106.2	103.8
Pulse	94	113	118	136	140	142	124
Resp.	25	32	25	38	33	38	32
Number	9	6	6	10	3	2	
Average Time Lived	33 M	2 2/10 H	4 5/10 H	16 H	40 6/10 H	3 1/2 D	

EXPECTANT TREATMENT

A patient, entering the hospital with a head injury, is put on the bed between blankets. Notes are taken of blood pressure repeatedly, and the temperature, pulse and respiration taken,—temperature hourly, pulse and respiration at fifteen minute intervals; one or more ice caps put to the head, and the patient is put in a semi-Fowler position. If he is in shock, stimulants are given—caffein sodium benzoate (5 to 7½ grains) or digifolin. If the patient is in pain or very restless, a sedative is given, morphine preferably, but usually not before a diagnosis has been made, as one-quarter (¼) grain morphine will mask symptoms to such an extent that it is very hard at times to use one's best judgment as to treatment. Other sedatives which may be used, if the patient is conscious, are the coal-tar products and bromides; if he is unconscious or irrational, they may be given by rectum. Fluids should be restricted.

The body reflexes, including pupillary, are taken and carefully noted. Unequal pupils,

or pupils not reacting to light, are symptoms of intracranial involvement. The eye grounds are examined and these findings are variable, but useful, especially in borderline cases, as a help in making a diagnosis. Urinary examination should be routine, and especially necessary before giving large doses of glucose.

The x-ray has not been employed as frequently here as in some other institutions. We have felt that keeping the patient quiet during the period of shock was of more importance than an x-ray picture. If the fracture was in the vault, or a compound fracture, comminuted fracture, it would be desirable to have not only an x-ray but a stereoscopic picture. We have felt that a negative x-ray picture of a basal fracture was worth nothing, and we have relied more upon other physical findings, though in many cases an x-ray is taken as a matter of record.

If the patient does not respond to palliative treatment; if the pulse and respiration drop; if he does not recover from a stupor, or goes into a deeper stupor, then further measures must be taken. Repeated injections of glucose are given intravenously in doses of forty (40) to one hundred (100) c. c. of fifty per cent (50%) solution and, if necessary, repeated at six hour intervals. It may also be necessary to do a spinal puncture, both as a diagnostic and therapeutic procedure, and it should be repeated if necessary.

The findings of the spinal manometer were not regularly tabulated at the time these records were made, but we feel at the present time that it is as important to record all spinal pressure readings as it is to keep a record of the blood pressure.

The subject of extradural hemorrhage should be mentioned. In many instances the patient, after the initial period of shock, feels quite well for a few hours, after which, quite rapidly, a stuporous or unconscious condition supervenes, with motor paralysis, and in the case of laceration of the middle meningeal artery, when we have a definite paralysis, one may say with considerable certainty that there is pressure from hemorrhage over the motor area on the opposite side. This condition may be of the contrecoup type, resulting from injury to the opposite side of the head, or blows on the jaw, and patients of this type have a high mortality rate. Operation should be seriously considered in every case.

In depressed, comminuted, or compound fractures, the decompression operation is indicated.

CONCLUSIONS

Among the conclusions to be observed from the charts are:

(a) The small percentage of open operations.

(b) The large majority of cases treated with expectant treatment only.

(c) That glucose was given, or spinal punctures done, in but twenty-four cases, or fourteen and five tenths per cent (14.5%).

(d) That blood pressure reading on entrance is in itself not of great importance unless followed by other blood pressure readings at regular intervals.

(e) That clinical findings for the first few hours, or during the shock period, are often misleading, unless the patient is observed for a time after the shock.

(f) That rest, observation, treatment of shock are the first requisites in the treatment of cranial or intracranial injuries.

(g) That patients who die in the first nine hours, die of shock or severe hemorrhage.

(h) That patients who die after nine hours, and up to four days, probably die of a lacerated brain.

(i) That patients who live past the first twenty-four hours after injury have ninety-seven chances out of one hundred to live.

SUMMARY

In closing, I wish to emphasize a few thoughts.

1. Every case of head injury is a problem in itself.

2. A general rule covering the treatment of all cases cannot be applicable, but that an outline of some treatment should be followed.

3. A factor of prime importance is the treatment of shock, rather than extensive diagnostic procedure, or radical treatment.

4. Roentgenological examinations are of value in cases in which open operation is deemed advisable and as a medico-legal record.

5. If you find unequal and fixed pupils, your prognosis is extremely grave.

6. The prognosis is extremely grave in those cases in which a rectal temperature of 103° is attained.

7. And finally, in all injuries to the head, or contusions to the face or jaw, or cervical spine, treat the case as a potential intracranial injury until a definite negative diagnosis has been made.

Gastro-Duodenal Ulcer; Factors That Determine Chronicity

By E. H. MENSING, M. D.
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Because of the complexity of the physiologic mechanism involved, there are undoubtedly many factors that must be responsible for the tendency of ulcer to become chronic or to recur. The term "recurrence" is often used improperly. The "re-activation" of an ulcer that has become indolent is often considered a recurrence. Whenever one has a case of gastro-duodenal ulcer that is resistant to any form of treatment or shows a tendency to recur after a symptom-free period, one should carefully study the various factors which enter into the production of chronicity of ulcer. The most important known factors are:

1. *Manner of Healing.* Healing of chronic ulcer occurs by formation of granulation tissue, proliferation of epithelium and fibro-plastic reaction. Excessive amount of scar tissue, especially when not covered by an epithelial layer, or when covered by an imperfect mucosa, is prone to result in new ulceration in the cicatrix.

The amount of fibro-plastic reaction is not alone dependent upon local conditions but varies considerably in individuals. The local conditions that determine the amount of cicatrization are principally (a) Amount of muscular activity at the site of the lesion, (b) Size of the lesion, (c) State of the circulation.

A comparatively large lesion located in a very active part of the stomach or duodenum, (ulcers are always located in the zones of greatest motor activity) and where the circulation is poor (the first portion of the duodenum has atypical circulation) must result in inadequate epithelization and excessive scar tissue formation. The excessive scar tissue undoubtedly reduces still further the blood supply to the epithelial cells.

An ulcer healed with little scar tissue and covered by a mucous membrane approaching the normal glandular structure is less likely to recur.

2. *Acid Erosion and Irritation.* Acid values that remain high after medical or surgical treatment are commonly associated with chronicity or recurrence, because acid undoubtedly has a retarding influence on the healing of ulcer. Usually these high degrees of acidity are due to reflex inhibition of pyloric relaxation, resulting in delayed evacuation, increased motility and interference with regurgitation of alkaline contents.

3. *Gastric Motility.* Lesions in the zones of greatest motor activity, namely lesser curvature, pylorus and first portion of the duodenum heal more slowly and with greater scar tissue formation than lesions in other portions of the stomach. Hence, the importance of applying physiological rest in order to obtain the best kind of healing with the least amount of scar tissue and the best kind of mucosal covering.

4. *Failure to Remove Foci of Infection.* Foci of infection in teeth, tonsils, sinuses, prostate, gall bladder and appendix play a role in the genesis of ulcer. Many clinical and laboratory observations point to duodenitis and gastritis as being the underlying condition. The lowered resistance in these areas yields to the acid erosion, with an ulcer resulting. Many experimental workers like Carlson are able to produce ulcer at will by first producing an inflammation. Hurst is of the opinion that the most common cause

of gastro-jejunal ulcer is some undiscovered focus of infection.

5. *Pyloric Drive and Pylorospasm.* The considerable force with which the chyme is ejected into the duodenum is dependent upon the size of the opening in the pylorus and the force of contractions of the stomach. When the pylorus is reflexly inhibited from relaxing as the result of an acutely inflamed ulcer, the intra-gastric pressure increases considerably. The pyloric drive under these conditions is considerable and must cause many of the "delicate epithelial cells formed in the process of healing to be swept away before they have had an opportunity to establish themselves as an integral part of the mucosa". (Mann)

Pylorospasm delays healing whether due to extrinsic causes as emotional stress, infected appendix or gall bladder, or from such intrinsic sources as an active ulcer. The effect of pylorospasm upon the pyloric drive has already been discussed.

6. *Mucosal Susceptibility.* The experimental work of Mann, Williamson, Ivy and others has shown that the jejunal mucosa is very susceptible to the effects of acid and it applies to a lesser extent to the duodenal mucosa. An inflamed duodenal mucosa, particularly when associated with vascular changes such as endarteritis or thrombus-formation must be more susceptible to acid than the normal.

7. *Food Irritation.* The contact of food with the delicate granulation tissue and epithelial cells in an ulcer must be a factor in retarding healing. The more prolonged contact of food in delayed evacuation, particularly when the food is coarse, must be detrimental.

8. *Emotional Stress.* Emotions play an important role in disturbing gastric motility as well as secretory functions. The modern-day stress must often produce hypertonus at the pylorus with delayed evacuation and increased motor and secretory activity. It is a fine point to determine how much of the patient's nervous make-up is to blame for the chronicity of his ulcer and how much of his nervous symptoms are due to long-continued suffering and anxiety.

9. *Tobacco, Alcohol and Condiments.* These can cause hyperacidity and disturbed gastric function.

10. *Disturbances of Acid-Neutralizing Mechanism.* Numerous influences play a part in these little understood functions. We do know that the mucin secreted by the mucous membrane of the stomach neutralizes free acidity. Furthermore the mucin acts as a protecting covering of the ulcer area.

Regurgitation of alkaline duodenal juice, as well as secretion of neutral chlorides from the gastric mucosa, undoubtedly play a role in the neutralization of free acid.

11. *Delayed Evacuation of Gastric Contents.* The more prolonged contact of ingested food results in a greater gastric phase of acid secretion with resultant higher acid values, and if the ulcer is proximal to the pylorus, there is a more prolonged contact of food with the ulcer.

12. *Colonic Stasis.* Gastric evacuation is delayed by any slowing up of peristalsis in the intestinal tract. Delayed gastric evacuation produces higher acid values with longer food contact. Hence the importance of treating constipation in chronic gastro-duodenal ulcer.

13. *State of Circulation about Ulcer Area.* Ulcers occur in areas of atypical blood-supply and greatest fixation, namely the first portion of the duodenum and the lesser curvature.

Mann has proven that chronic perforating ulcers showed the least amount of healing and he showed furthermore that this type of lesion was invariably accompanied by marked vascular changes, particularly endarteritis and thrombosis in the base of the ulcer.

14. *Local Trauma.* The trauma to an ulcer from coarse or indigestible food, as well as the trauma that must result from excessive activity, particularly pylorospasm, must retard the proliferation of the delicate epithelial cells. Excessive scar tissue that usually results from excessive motor activity exposes the mucosal cells to further trauma by fixing them to underlying structures.

SUMMARY

Whenever one encounters a chronic ulcer of the stomach or duodenum one should think of the fourteen principles enumerated above.

An attempt at healing is interfered with by numerous factors. By endeavoring to reduce the amount of scar tissue and favor the amount of epithelization, one is likely to obtain the best healing with the least likelihood of chronicity or recurrence.

THE JOURNAL CLINIC

Ulcer: Report of a Case of Ruptured Duodenal Ulcer Operated Upon During the Onset of a Lobar Pneumonia

By C. J. SMILES, M. D.
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The following case presents some unusual conditions and is brought to your attention because of difficulty in diagnosis and, in the surgical procedure, in which the whole problem is simplified by using spinal anesthesia.

Patient: The patient was a young man of 28 years whose occupation was that of a freight handler.

Chief Complaint: The patient said he had felt badly for three days before coming to the hospital on March 11, 1931. He had had pain in his abdomen to the right and above the umbilicus. On the morning of the day of his admission he had felt worse but he went to work lifting freight and pulling trucks around the station. One item of his work that morning was lifting packages of cheese that weighed one hundred pounds each. At 11:30 A. M., he went to his home and ate lunch which consisted of potatoes, meat, bread, butter and coffee. He returned to his work at 1 P. M. and about 2 P. M. developed a sudden severe pain in the epigastrium accompanied by faintness. He sat down for a time, then got up and finished lifting seven or eight pieces of freight. Cramps and faintness followed. Soon he found he could not breathe or talk without pain. He perspired profusely. A doctor was called to see him at the station. He was supplied with medicine, told to go home and go to bed. He became worse and was sent to the hospital at midnight.

Past History: He had been bothered with gas on his stomach for seven or eight years, always at the height of digestion or about two hours after eating. This was always relieved by food. He had a mild attack of influenza in 1918. He underwent an operation for appendicitis in 1924 for the above symptoms. No x-ray was taken before that operation but the surgeon reported he found no ulcer although he had searched carefully for one.

Examination: Physical examination revealed a slender man with anxious expression and with bright red spots on each cheek. His nostrils were dilating with each inspiration. He lay curled up on his left side, his hands doubled over his abdomen, and he could not be moved. The right lung was consolidated throughout the lower lobe and there were all the typical pneumonic findings over that area. The abdomen was hard and retracted so much that the examination revealed nothing else. The leukocytic count was 21,000. Temperature was 102.2; pulse —110. The urine was reported as follows: Amount, 120 cc. Albumin, negative; sugar, negative; sp. gr. 1040; microscopic was negative for pathologic constituents. The sputum was thick and contained a few pus and blood cells and many organisms recognized later as pneumococci.

Operation: The operation was done under spinal anesthesia, 8 cc. of three per cent novocain being used. We found and closed with superimposed purse string sutures a large ruptured ulcer on the anterior surface of the first portion of duodenum, following which a posterior gastro-enterostomy was performed. The wound was drained by a piece of rubber dam. The immediate after-treatment consisted of five per cent glucose intravenously and hypodermoclysis of normal saline. Later, a daily injection of pneumococcus immunogen was given. A moderate fluid intake was kept up by saline given subcutaneously and rectally. Resolution with characteristic sputum began on the ninth day after a vary-

Fig. I. Taken on tenth postoperative day.

Fig. II. Taken on twenty-first postoperative day.

ing temperature of 101 to 103 degrees, with a pulse of 100 to 130. An x-ray of his chest was taken on the tenth day which showed a resolving pneumonia. The abdomen gave no symptoms except that the wound had opened due to coughing and had to be re-sutured on the twenty-first day. This healed very well. On the twenty-eighth day he developed a mild phlebitis of the left leg, which later cleared up with a slight residual swelling.

A follow-up report received from the patient on November 2nd, 1931, indicates that he considers himself in excellent physical condition. He is doing hard work, eating a mixed diet, and he has increased his weight from 130 pounds at the time of his operation to 170 at date of report.

CONCLUSION

(1) It is our opinion that the lung condition was a true lobar pneumonia, although by many it might be called a trans-diaphragmatic pneumonitis due to peritoneal inflammation.

(2) To spinal anesthesia belongs the praise for our assurance and confidence in going through this surgical procedure to a successful recovery. This is in great contrast to similar experiences of a few years ago when the more irritating inhalation anesthetics were used or when we used a local infiltration method and did an entirely unsatisfactory operation and one beset by many difficulties that we do not encounter in spinal anesthesia.

Progressive Lipodystrophy; With Case Report

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Progressive lipodystrophy is a relatively rare condition, up to 1926, only 60 cases having been reported (1). The syndrome has been defined by Wechsler (2) as a trophoneurosis which begins in childhood. It consists of a thinning of the face, upper part of the body and arms and is commonly associated with a hyperplasia of the fatty tissues of the hips and thighs.

The first case was noted by Osler in 1895 and later described by Weber (3). A report was made by Campbell in 1907 and in the same year Barranquer (4) gave a discussion of the subject. In 1911 Simons (5) published a case presenting an entire atrophy of the facial fat — simulating a "death mask,—fatty atrophy of the arms and trunk and hypertrophy of the fat about the hips—

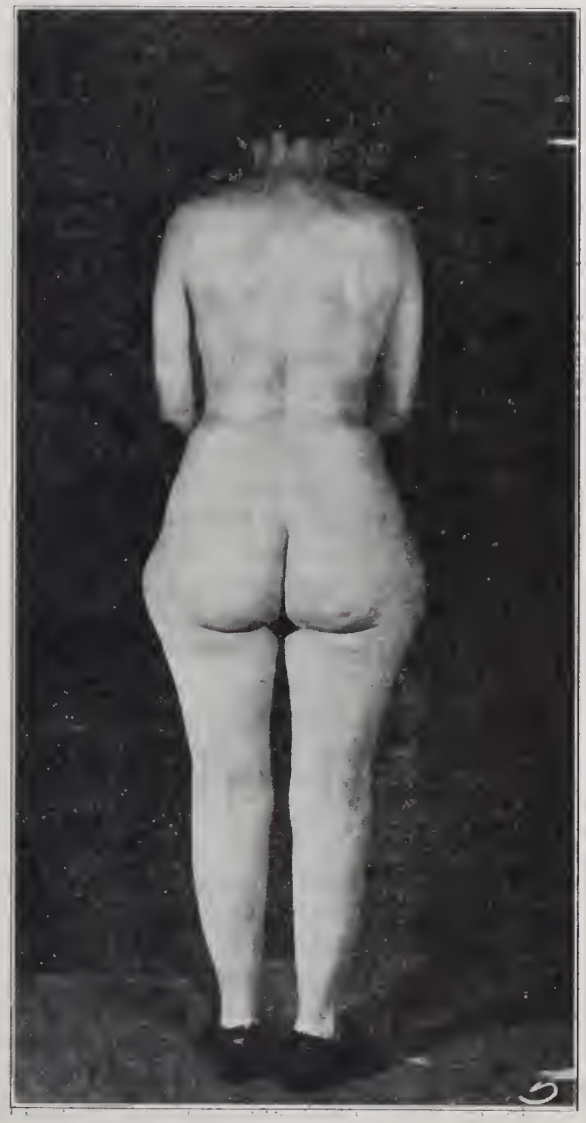
'reminding one of a Hottentot woman'." He also noted a spotty and general bronzed "dirty" appearance of the skin, otherwise physical findings were negative. To this syndrome he gave the name Progressive Lipodystrophy.

The predisposing and exciting factors are unknown; a poly-glandular dysfunction has been considered most probable. Hyperthyroidism was found to be present in 8 out of 10 cases reported by Maranon (6). Women are more frequently affected than men, although the condition may occur in both sexes (7). In two cases which came to autopsy, brain tumors were found (8)—hypophysis and corpus striatum.

Histological sections taken from the scalp and upper extremities show a normal epidermis and corium with marked decrease or complete absence of subcutaneous fat. The onset is in childhood, mostly around puberty. The progression is extremely slow and insidious. There is, as a rule, no discomfort other than a cosmetic one, although pressure symptoms from the fatty hypertrophy have been noted. The syndrome has no bearing whatsoever on the duration of life.

The treatment of lipodystrophy has been unsatisfactory. Some authors (9) report the subcutaneous injection of paraffine or auto fat transplantation into the atrophic areas, but beyond accomplishing a cosmetic effect it is of no value. Various polyglandular preparations have been employed without success. Recently R. Boller (10) has

(Continued on page 210)



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EDITORIALS

THE DIET IN HYPERTENSION

IN SPITE of all the clinical and experimental work which has been done in recent years, all tending to substantiate the view that hypertension begins as a wide-spread constriction of artérioles and later results in actual anatomical vessel-wall changes, the idea is still wide-spread among physicians that a special diet will reduce the high blood pressure.

Invariably the specific diet is meat-free. This recommendation of the efficacy of a meat-protein free diet must have had its origin at the time when, thirty years ago, hypertension of itself was considered to be most harmful and some well-known medical publicist wrote, that meat was harmful.

Much has been learned about the relative harmlessness of hypertension since the introduction of the sphygmomanometer, but the old diet is still advised.

Some years ago Strouse and his co-workers at Michael Reese Hospital, Chicago, took a series of persons with hypertension and, after having made the blood pressure relatively stable by rest, fed them large amounts of meat-protein, both red and white. They concluded that protein of meat had absolutely no effect on blood pressure. We are now seeing articles in medical literature relating cases of anemia due to faulty diet. And it has been shown by Whipple and his co-workers that the most powerful stimulus to the erythropoietic bone marrow is hemoglobin itself. This hemoglobin is naturally derived from the meat which we eat.

There are people who eat no meat, either from religious or other scruples, yet keep quite well. They usually derive their erythropoietic stimulus from the yolks of eggs and what little there is in some vegetables. The average human is still an omnivorous animal and eats his meat with relish.

The body must have all the amino-acids in order to store up protein. Some of the important amino-acids are not found in vegetables or found in such small amounts that in order for a man to acquire enough in a vegetable diet he must eat great quantities of vegetables. Further it has been found that the protein end-products of vegetables are more difficult for the human kidney to eliminate than are those of meat. McCann,* speaking of protein in nephritis, says, "These experiments (feeding large amounts of protein) have convinced us that liberal protein allowances in the diet do not of themselves injure the kidney."

Those who put patients with hypertension on an almost protein-free diet lose entire sight of the fact that the body even at rest burns up protein, the end-products of which are excreted through the kidneys and that the normal wear and tear must be replaced by protein. It is not the kind of food eaten which harms the kidneys or any other part

* McCann, W. S. Ann. Int. Med. 5:579, 1931 (Nov.)

of the body, it is the quantity. Ask any person with hypertension what he has eaten for the three days before he consulted you and you will find that he has consumed two or three times too much food.

Quite recently an able clinician remarked that if there were any drug or special method to reduce permanently a long-standing hypertension he was ignorant of it. The writer agrees with this remark.

The treatment of hypertension must be carried out by every doctor. Patients still demand it.

But let us be sensible. Let us remember that starvation anemia is worse than high blood pressure. Let us by advice as to reasonable diet, reasonable living in general, keep our patients happy. Let us not be charlatans, telling them we can do something which we cannot do.

Advise them to eat much less food but let the quality be to their liking. Hypertension is a condition which usually continues for years so that we should plan the diet with the object of keeping these people in the best state of nutrition. Most authorities now do not believe that this can be done by limiting the most essential food stuff in the diet. L. M. W.

THE SEROLOGY OF SYPHILIS

MOST authorities recognize certain deficiencies in the present serological diagnosis of syphilis, whether the methods are based on some modification of the complement fixation reaction (Wassermann) or on precipitation changes (Kahn-Hinton-Kline, etc.). Under the auspices of The League of Nations, the principal modifications of these reactions have been subjected to critical analysis, under controlled circumstances, at conferences in Copenhagen, 1928, and Montevideo, 1930. At both of these conferences, the Kahn test, in the hands of its originator, proved its superiority. However, it was the opinion of the judges that the exclusive use of any test, i. e. the Kahn, could not be advocated at this time. Instead, they urged, that representative tests of both types be checked against each other, particularly in questionable cases.

In a recent lecture Kahn reviewed the situation and emphasized two major advantages of his test in comparison with others. First, it is extremely sensitive giving a high percentage of positive reactions in proved cases of syphilis. Second, it has an increased specificity which practically eliminates the occurrence of false positives.

For experimental purposes Kahn is also using a more sensitive reaction designated as the "presumptive Kahn." While it detects a larger percentage of positive reactors, it is less specific and occasional false positives occur. Where the tests can be satisfactorily controlled, he advises the use of both tests in doubtful cases. Under such conditions a negative "presumptive Kahn" would practically eliminate the possibility of syphilis, while a positive standard Kahn could be regarded as conclusive evidence of syphilis. The "presumptive Kahn" is of further value in following such serological changes as occur during antisyphilitic treatment.

Like all laboratory procedures, serological tests for syphilis, including the Kahn, are subject to variation in the hands of different operators, and their results should be subjected to critical review before any decisive steps are taken in questionable cases. Despite an apparent superiority, the Kahn test has not received the unanimous acceptance which would seem indicated. This probably accounts for the reluctance on the part of many laboratories to substitute it for the time honored Wassermann reaction. J. H.

PUBLICATION OF PAPERS

SOME misunderstanding develops from time to time regarding the publication of papers in the JOURNAL. Articles presented at the Annual Meeting constitute the bulk of the material published during the subsequent year. It becomes evident that, if each issue of the JOURNAL is to appeal to its readers, proper distribution and grouping of papers must be made. This will necessitate considerable delay in the publication of some papers. The date of publication has nothing to do with the quality of a paper, but for the best interests of the JOURNAL an equable distribution among the twelve issues should be made. J. H.

THE PRESIDENT'S PAGE

Otto A. Gaedke

THE SHOULDERS RESOLUTION AGAIN

THE question of insurance benefits in lieu of federal hospitalization as a means of caring for disabled veterans of the War was discussed on this page of the November issue of the Journal. Since that time considerable water has gone by the mill.

In November the special Legislative Committee of the American Medical Association met with the Rehabilitation Committee of the American Legion in Indianapolis. Not much was accomplished at this meeting, but a contact was effected and on the part of our committee we had a better appreciation of the position of the veterans, and I believe that they were led to appreciate our position with regard to veterans' legislation.

The second conference of these committees was held at the American Medical Association headquarters in Chicago the last of January. At that time certain definite conclusions were reached: 1. That the medical profession was not opposed to the Legion's program of hospitalization in the Bureau hospitals for veterans suffering from service connected disabilities and those suffering from diseases that may be assumed to have had service origin, namely, neuropsychiatric, tuberculous, paralytic dementia, amoebic dysentery, and encephalitic patients. 2. On the part of the Legislative Committee we desired that there should be a cessation in the building program of the Veterans' Bureau for any hospitals other than those necessary to take care of the above mentioned groups of cases. The Legion's representatives did not agree to this program. 3. In the discussions which took place it was evident that they desired further than emergency cases of accident or illness occurring among veterans, should receive hospitalization and medical and surgical care in civilian hospitals and under civilian physicians at government expense. This proposition met with the approval of the representatives of the medical association.

The third conference was held in Washington when the above mentioned representative committees again met and also had a joint meeting with the Veterans' Administration. Nothing further was accomplished at this conference and particularly were we unable to secure an agreement to the cessation of further hospital building for complete care of veterans with non-service connected disabilities. Representatives of the American Medical Association and the American Hospital Association appeared before the Committee on Veterans' Legislation of the House in favor of Con-

gressman McClintnic's bill which, if enacted, would provide for the care of veterans in civilian hospitals, but would not limit such hospitalization and care to emergency cases. Rather, it is to apply to all cases. We felt that we could support such a measure. In the conference it was evident that in the minds of some of the members of the committee a certain degree of socialized medicine was considered quite necessary and advantageous. Certain members felt that not only the veterans were entitled to such service, but that many of the population with incomes in the lower brackets might very well receive such service. In view of all this, it seems to me that it would be very advantageous for the committee to proceed with its program of information relative to the advantages of cash benefits in lieu of hospital benefits to all veterans' organizations.

In Wisconsin your president appeared first in Milwaukee, by request, before a group of about 150 service officers of the various Posts of the State and discussed the matter with them. As a result of this meeting a conference was held with the Department Commander of Wisconsin, Dr. C. A. Dawson, and a liaison committee of the State Medical Society and the Legion of the Wisconsin department was appointed. This committee met in Milwaukee and drafted a resolution favoring the investigation of the Shoulders Resolution by the State department of the Legion. This report was submitted to the Executive Council of the Legion at its mid-winter conference in Madison, which then, in turn, appointed a committee which should make a report to the next conference for submission to the State convention some time during the year. The whole matter was also presented to the body of those present, probably from three to four hundred men who looked with distinct favor upon the provisions as outlined in the Shoulders Resolution and as indorsed by the House of Delegates of the American Medical Association. But it is quite apparent that the Veterans' Administration and in a certain measure the Rehabilitation Committee of the American Legion are opposed to any change in the program as now in force and as outlined by them for the erection of a large additional number of federal hospitals throughout the United States.

When the matter has been fully explained to them, the rank and file of the Legion members as well as the physicians are decidedly in favor of the cash benefits as evidenced by the requests for information on this matter general public and the taxpayer are all to be benefited, and since the as a concomitant to this the civilian hospitals, the general practitioner, the general public and the taxpayer are all to be benefited, and since the House committee does not seem averse to such a proposition, it would appear that we should proceed with our campaign to carry the somewhat modified provisions of the Shoulders Resolution into effect. If the other States in the Union were as far along with such a program as we are in Wisconsin, it is my firm belief that within a period of a few years we would have attained our ends in which it seems certain that all groups involved would be very benefited and we would prevent the establishment of another great and expensive Bureau in the federal government as is now proposed and beginning operation.

THE STATE MEDICAL SOCIETY OF WISCONSIN

ORGANIZED 1841

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LIST OF EXECUTIVE OFFICERS OF COUNTY MEDICAL SOCIETIES

County	President	Secretary
Ashland-Bayfield-Iron	John M. Dodd, Jr., Ashland	J. W. Prentice, Ashland.
Barron-Washburn-Sawyer-Burnett	C. F. Cronk, Cameron	A. D. Galloway, Barron.
Brown-Kewaunee	E. S. Knox, Green Bay	W. E. Mueller, Green Bay.
Calumet	A. C. Engel, New Holstein	A. F. Slaney, Hilbert.
Chippewa	F. T. McHugh, Chippewa Falls	J. A. Kelly, Chippewa Falls.
Clark	R. R. Rath, Granton	A. L. Schemmer, Colby.
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Crawford	A. E. Dillman, Steuben	C. A. Armstrong, Prairie du Chien.
Dane	F. F. Bowman, Madison	F. L. Weston, Madison.
Dodge	E. P. Webb, Beaver Dam	A. W. Hammond, Beaver Dam.
Door	John Hirschboeck, Forestville	
Douglas	H. A. Sincock, Superior	C. H. Christiansen, Superior.
Eau Claire and Associated Counties	E. E. Tupper, Eau Claire	P. G. Spelbring, Eau Claire.
Fond du Lac	J. C. Yockey, Fond du Lac	H. R. Sharpe, Fond du Lac.
Grant	E. A. A. Dunn, Platteville	M. B. Glasier, Bloomington.
Green	W. B. Gnagi, Sr., Monroe	J. F. Mauermann, Monroe.
Green Lake-Waushara-Adams	G. E. Baldwin, Green Lake	A. J. Wiesender, Berlin.
Iowa	S. R. Ridley, Mineral Point	H. M. Walker, Dodgeville.
Jefferson	A. C. Nickels, Watertown	A. A. Busse, Jefferson.
Juneau	C. A. Vogel, Elroy	A. T. Gregory, Mauston.
Kenosha	A. Schlapik, Kenosha	W. H. Lipman, Kenosha.
La Crosse	R. L. Eagan, La Crosse	G. D. Reay, La Crosse.
Lafayette	R. B. Quinn, Darlington	W. B. Williams, Argyle.
Langlade	C. E. Zellmer, Antigo	J. C. Wright, Antigo.
Lincoln	F. L. Kelley, Merrill	W. H. Bayer, Merrill.
Manitowoc	C. H. Barnstein, Newton	E. C. Cary, Reedsville
Marathon	Joseph F. Smith, Wausau	Verne E. Eastman, Wausau.
Marinette-Florence	T. J. Redelings, Marinette	C. H. Boren, Marinette.
Milwaukee	P. M. Currer, Milwaukee	Theo. Wiprud, Ex. Sec'y, Milw.
Monroe	A. E. Winter, Tomah	H. H. Williams, Sparta.
Oconto	R. J. Goggins, Oconto Falls	G. W. Krahn, Oconto Falls.
Oneida-Forest-Vilas	C. D. Packard, Rhinelander	I. E. Schiek, Rhinelander.
Outagamie	E. F. Mielke, Appleton	R. V. Landis, Appleton.
Pierce-St. Croix	H. P. Conway, Spring Valley	A. E. McMahon, Glenwood City.
Polk	L. O. Simenstad, Osceola	Geo. B. Larson, Frederic
Portage	F. A. Marrs, Stevens Point	H. P. Benn, Stevens Point.
Price-Taylor	F. W. Mitchell, Medford	G. E. MacKinnon, Prentice.
Racine	C. O. Schaefer, Racine	Susan Jones, Racine.
Richland	W. C. Edwards, Richland Center	G. Benson, Richland Center.
Rock	G. S. Metcalf, Janesville	E. C. Hartman, Janesville.
Sauk	Roger Cahoon, Baraboo	A. C. Edwards, Baraboo.
Shawano	C. E. Stubenvoll, Shawano	L. W. Peterson, Shawano.
Sheboygan	H. F. Deicher, Plymouth	A. C. Radloff, Plymouth.
Trempealeau-Jackson-Buffalo	R. L. Alvarez, Galesville	R. L. MacCornack, Whitehall.
Vernon	W. M. Trowbridge, Viroqua	Wm. H. Remer, Chaseburg.
Walworth	S. G. Meany, East Troy	V. S. Downs, Lake Geneva.
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Waukesha	J. C. Hassall, Oconomowoc	J. F. Wilkinson, Oconomowoc.
Waupaca	R. K. Irvine, Manawa	F. J. Pfeifer, New London.
Winnebago	G. E. Forkin, Menasha	M. C. Haines, Oshkosh.
Wood	F. X. Pomainville, Wisconsin Rapids	W. G. Sexton, Marshfield.

SOCIETY PROCEEDINGS

BARRON-WASHBURN-SAWYER-BURNETT

The following were elected members of the Barron-Washburn-Sawyer-Burnett County Medical Society at its January meeting: Dr. P. K. Edwards, Barron; Dr. C. F. Cronk, Cameron; Dr. W. D. Rydell, Rice Lake; Dr. R. E. Thompson, Cumberland

Mr. J. G. Crownhart, Secretary of the State Society spoke on "Trends in Medicine".

Officers elected for 1932 are the following: President, Dr. C. F. Cronk, Cameron; Vice-President, Dr. C. C. Post, Barron; Delegate, Dr. J. H. Wallis, Rice Lake; Alternate, Dr. S. O. Lund, Cumberland; Secretary-Treasurer, Dr. A. D. Galloway, Barron.—A. D. G.

BROWN-KEWAUNEE

The first meeting of the Brown-Kewaunee County Medical Society for the year of 1932 was held January 21st, at 6:00 P. M., at the Hotel Beaumont, Green Bay. Dr. Knox opened the meeting and thanked the Society for electing him president. Dr. Mueller was unable to attend because of a relative's death.

Harold Malchow, member of Assembly from our district gave a talk on recent legislation relating to medical practice.

An interpretation of the recent (1931) law relating to sending patients to the Wisconsin General Hospital, or for care in the local hospital, was given.

A ten minute paper was given by Dr. D. F. Gosin, Green Bay, of a patient with splenic anemia. This paper proved very interesting.

Dr. E. S. Schmidt, Green Bay, a member of the Grievance Committee reported on a talk given over WHBY praising optometry.

The unfinished business, federal hospitalization of ex-service men and the Shoulders Resolution, was brought before the society. Dr. P. R. Minahan read a resolution in favor of the Shoulders Resolution. This resolution is to be sent to all county societies and to the State Medical Society for concerted effort on federal legislation.

The resolution follows:

"Whereas: The government of the United States has, by legislation, increased the number of ex-service men privileged to hospital care at Federal expense and

"Whereas: The present government hospital capacity being insufficient for the accommodation of the great increase of patients resulting from the enactment of laws relative to hospitalization of ex-service men for diseases not connected with military service and

"Whereas: The cost of new hospital buildings to the government having been estimated at approximately $360,000,000; and administration and maintenance costs requiring $219,000,000 annually; and the fact that the projected hospitals would be used for but a few years and then probably abandoned; and the long travel from their homes of service men to government hospitals for treatment for disease not connected with service, would be uncertain, inconvenient, and at times hazardous and not favored by the majority of service men; and the cost, constituting a treasury rate at a time when economy in government should be a patriotic purpose and

"Whereas: The cost of this same service in civilian hospitals where there are sufficient beds which can be secured by direct government aid to the individual service man, enabling him to seek treatment in civilian hospitals with his own choice of physician, which is his own American privilege; and

"Whereas: The direct aid to the ex-service man can be secured as efficiently for an estimated cost of $92,000,000 per year, which would cover hospital service, and a weekly cash payment of $20.00 to his family, without the expenditure of vast sums for hospital construction and

"Whereas: All these considerations operate to make this direct aid plan preferable in every particular, with reference to cost, convenience, and character of service, to the bureaucratic, un-American program now proposed in many quarters for treatment of diseases not related to service.

"Now, Therefore, Be It Resolved, That the sense of the Brown-Kewaunee County Medical Society is that the direct aid plan is in all ways superior, besides constituting a patriotic duty and

"Be It Further Resolved, That a copy of this resolution be sent to ex-service men's organizations, senators, representatives, officers of State Medical Society, county medical societies, and other organizations concerned with bettering governmental relation with ex-service men.

"EUGENE S. KNOX,
President.
"WALTER E. MUELLER,
Secretary."

The resolution was lost by which the county medical society supply all necessary aid to any physician for taking care of indigent sick. (4 to 10)

A motion was made to instruct our delegate to the State Society to equalize costs for county and state for county-cared-for patients under state care.

It was suggested that a card announcing the date for each meeting be mailed ten days previous to the regular program announcement, thus securing a better attendance at the meetings.

There being no further business the meeting was adjourned.

On February 18th, the regular monthly meeting of the Brown-Kewaunee County Medical Society was held at the Hotel Northland, Green Bay.

After dinner, the meeting was called to order by the President, Dr. E. S. Knox. Minutes of the previous meeting were read and accepted. A report was given by the Committee on the Shoulders Resolution. Through the report of this committee it was learned that the Shoulders Resolution is very acceptable to the various veterans' organizations.

Drs. J. B. Mac Laren, V. F. Marshall and C. D. Neidhold, of Appleton gave interesting talks on the "Outagamie Plan of Conducting the Various Public Clinics." A general discussion followed these talks.

A Public Relation Committee was appointed consisting of Dr. McCarey, one year, Dr. Fuller, two years, and Dr. Carter, three years.

There being no further business the meeting was adjourned. W. E. M.

DODGE

The annual meeting of the Dodge County Medical Society was held at the Lutheran Deaconess Hospital in Beaver Dam on January 28th. The officers of the preceding year were re-elected for another year consisting of Dr. E. P. Webb, Beaver Dam, president; Dr. J. H. Karsten, Horicon, vice-president, and Dr. A. W. Hammond, Beaver Dam, secretary. A. W. H.

EAU CLAIRE

Members of the Eau Claire and Associated Counties Medical Society met at Hotel Eau Claire for a dinner meeting on January 25th. Following the dinner, Dr. George B. Eusterman of Rochester presented the subject of "Achlorhydria", discussion of which was opened by Drs. H. F. Derge and G. Hoyme, both of Eau Claire. Immediately following Dr. Eusterman's paper, Dr. Waltman Walters of Rochester presented the subject of "Recent Developments in the Surgical Treatment of Ulcerating Lesions of the Stomach and Duodenum" and discussion was opened by Drs. E. L. Mason and Nels Werner, also of Eau Claire. A general discussion followed the presentation of these two papers in which a large group of the membership participated.

Mr. George Crownhart, secretary of the State Society, gave an address on "Trends in Medicine". Dr. H. M. Stang, councilor for the Tenth District, discussed the activities of the Council at its January meeting. Adjournment was taken at eleven-thirty P. M. Forty-two attended the meeting.

FOND DU LAC

A dinner meeting was held by the Fond du Lac County Medical Society at the Hotel Retlaw, Fond du Lac, on February 10th at six-thirty o'clock.

Dr. Philip H. Kreuscher, Chicago, clinical professor of orthopedic surgery, Loyola University School of Medicine, was the principal speaker, his subject being "Fractures of the Bones Near Joints."

GREEN LAKE–WAUSHARA–ADAMS

The Green Lake–Waushara–Adams County Medical Society held a dinner meeting at Hotel Whiting, Berlin, on January 22nd. Following the dinner, an address was given by Dr. E. L. Miloslavich of Milwaukee.

IOWA

A meeting of the Iowa County Medical Society was held at St. Joseph's Hospital on February 4th at Dodgeville, beginning at noon with an excellent dinner served by the Sisters and thoroughly enjoyed by all present. Following the dinner, the meeting was called to order and the following officers were elected for 1932:

President, Dr. S. R. Ridley, Mineral Point; vice-president, Dr. M. T. Erickson, Highland; secretary, Dr. H. M. Walker, Dodgeville; delegate, Dr. M. T. Erickson; alternate delegate, Dr. M. W. Trentzsch, Highland; councilors, Drs. S. R. Ridley, W. J. Pearce, Dodgeville; T. A. Hagerup, Dodgeville.

A committee of three was appointed to meet with the County Poor Commission to attempt adoption of a standardized fee schedule for indigent cases, and of a plan whereby such cases might be accepted and approved by the Commission with greater facility than at present. H. M. W.

KENOSHA

At the annual meeting of the Kenosha County Medical Society held in January, the following were elected officers for 1932: President, Dr. Alexander Schlapik, Kenosha; Vice-President, Dr. C. C. Gascoigne, Kenosha; Secretary-Treasurer, Dr. W. H. Lipman, Kenosha.

Dr. Frank E. Simpson of Chicago was speaker at a regular meeting of the Society held on January 26th in the Chamber of Commerce rooms at Kenosha. Dr. Simpson spoke on the technicalities of the treatment of cancer by radium.

MANITOWOC

Dr. Charles H. Barnstein, Newton, was named president of the Manitowoc County Medical Society at the annual meeting held at Hotel Manitowoc on January 18th. Dr. C. L. R. MacCollum, Manitowoc, was elected vice-president and Dr. E. C. Cary, Reedsville, is secretary and treasurer, succeeding Dr. Barnstein. Dr. Eugene Gates, Two Rivers, and Dr. F. W. Hammond, Manitowoc, were named as delegates to the annual meeting of the State Medical Society and Dr. William A. Rauch, Valders, was elected as alternate.

Dr. A. P. Zlatnik of Two Rivers was a speaker at this meeting.

MILWAUKEE

The monthly meeting of The Medical Society of Milwaukee County was held in the Hotel Pfister on February 12th.

Following routine business and announcements of interest to members, Dr. M. G. Peterman gave a brief discussion on "Intestinal Obstruction of New Born Infants," accompanied by motion pictures, and Dr. D. B. Phemister, professor of surgery, Univer-

sity of Chicago Medical School, presented a paper on "Gall Stones."

Dr. Irving Schulz discussed Dr. Peterman's paper, and that of Dr. Phemister was discussed by Dr. Chester M. Echols.

There were 220 present.

POLK

Dr. A. A. Pleyte of the Wisconsin Anti-Tuberculosis Association gave a discussion of "Tuberculosis of the Teen Age" before a joint dinner meeting of the Polk County Medical Society and the dentists of Polk County, on January 18 at Osceola.

On January 22, the Polk County Medical Society was the guest of the Polk County Dental group. The purpose of the meeting was to meet on common ground and develop a school public health plan. The speakers of the evening were Dr. H. M. Guilford of the State Board of Health, and Mr. J. George Crownhart. At the close of the meeting a committee was chosen to work out the details for our school examination program. G. B. L.

RACINE

At the regular meeting of the Racine County Medical Society held on January 21st, Judge J. Allen Simpson discussed "The Admission of Patients to Racine County Hospitals as County Charges." Dr. C. C. Edmondson of Waukesha spoke on "Diabetes", and Dr. R. M. Kurten of Racine presented a paper on "The Physiology of the Sex Cycle."

A newly organized board of directors was chosen, consisting of the president, Dr. Carl O. Schaefer, Racine; the secretary, Dr. Susan Jones, Racine; the retiring president, Dr. J. F. Bennett of Burlington, and two members elected from the floor, Dr. L. E. Fazen and Dr E. Von Buddenbrock, both of Racine.

Dr. I. F. Thompson, Racine's newly appointed health officer, was introduced by Dr. C. O. Schaefer, who welcomed him in the name of the Society and expressed the desire to cooperate with him in his assigned work.

The regular meeting of the Racine County Medical Society was held at the Racine Elks Club on Wednesday evening, Feb. 17th, at eight o'clock.

Two papers were read. Dr. Forrester Raine of Milwaukee presented a discussion on intestinal obstruction, and Dr. Leon Bloch, gastroenterologist at the Michael Reese hospital in Chicago, discussed genitourinary conditions, simulating gastrointestinal diseases. Physicians from the Kenosha Medical Society were also in attendance.

A committee on public health and legislation was appointed. Acting on this committee, in cooperation with Dr. I. R. Thompson, city health commissioner, are Drs. L. E. Fazen and Paul Hahn of Racine and R. W. McCracken of Union Grove. S. J.

RICHLAND

Dr. W. C. Edwards of Richland Center was named president of Richland County Medical Society at its annual meeting held recently. Dr. L. L. Hines of Rockbridge was elected vice-president; Dr. Gideon Benson, Richland Center, secretary and treasurer; Dr. W. R. Coumbe, Richland Center, member of the Board of Censors; Dr. George Parke, Viola, delegate to the annual meeting of the State Society, and Dr. B. I. Pippin, Richland Center, alternate delegate.

ROCK

The January meeting of the Rock County Medical Society was held on the 26th at the Monterey Hotel, Janesville.

Dr. Robert S. Berghoff, professor of medicine at Loyola University, Chicago, and Dr. R. K. Packard, Woodlawn Hospital, Chicago, were the principal speakers on the program.

SAUK

Dr. William S. Middleton of the University of Wisconsin and Dr. R. H. Juers of the Marshfield Clinic were guest speakers at a dinner meeting of the Sauk County Medical Society held at the Warren House, Baraboo, February 18th.

TREMPEALEAU–JACKSON–BUFFALO

At the annual meeting of the Trempealeau–Jackson–Buffalo County Medical Society held at Arcadia, November 12th, 1931, Dr. R. L. Alvarez, Galesville, was elected president, and Dr. Elizabeth Comstock, Arcadia, vice-president. Dr. R. L. MacCornack, Whitehall, was re-elected secretary and treasurer, and Drs. C. F. Peterson, Independence, and H. A. Jegi, Galesville, re-elected delegate and alternate respectively. R. L. M.

WAUKESHA

The Waukesha County Medical Society met on January 6th, with the following speakers and their subjects on the program:

"The Normal Diet" by Dr. W. E. Nicely of The Spa, Waukesha.

"The Results of Research on Vitamins" by Dr. C. C. Edmondson, also of The Spa.

"The Digestion, Absorption and Metabolism of Fats" by Dr. John D. Wilkinson of Oconomowoc.

The entire program was very interesting and of decided benefit to the members present.

Officers elected for the year 1932 are: President, Dr. J. C. Hassall, Oconomowoc; vice-president, Dr. R. D. Thompson, Statesan; secretary-treasurer, Dr. J. F. Wilkinson, Oconomowoc; delegate and alternate re-elected.

By vote of the society, the name of Dr. M. R. Wilkinson, Oconomowoc, was chosen and presented to the county board of Waukesha County to serve as a member of the committee of the county board on public health matters. J. F. W.

WAUPACA

A meeting of the Waupaca County Medical Society was held at the Central Hotel in Manawa on January 27th. Following the dinner at six-thirty o'clock, Dr. H. M. Coon of Stevens Point gave an

address on "Misconception as to Pulmonary Tuberculosis." This was followed by a talk on the new State Hospital law by Judge William N. Martin of Waupaca.

WINNEBAGO

The Winnebago County Medical Society met on Friday evening, January 15th, in the staff room at Mercy Hospital, Oshkosh. Dr. Neil Andrews, Oshkosh, presented a paper on "The Heart, Past and Present."

GREEN BAY ACADEMY OF MEDICINE

The Green Bay Academy of Medicine held its February meeting in the Bellin Memorial Hospital, Green Bay, February 10th. Dr. Herman Henrickson of Green Bay presented a paper on "Myocarditis" discussions of which were opened by Drs. E. M. Jordan and W. P. Tippet. This was followed by a paper on "Surgical Treatment of Peptic Ulcer" by Dr. C. S. Williamson.

MILWAUKEE ACADEMY OF MEDICINE

Members of the Academy of Medicine met at eight o'clock on Tuesday evening, February 16th. The following program was given:

"Pituitary Dwarfism; Report of a Case" by Dr. Louis M. Warfield.

"Diagnosis and Treatment of Acute Intestinal Obstruction" by Dr. Owen H. Wangensteen, chief, department of surgery, Medical School, University of Minnesota, Minneapolis.

MILWAUKEE HOSPITAL INTERNS

The Milwaukee Hospital Interns' Association held its first meeting of 1932 on January 20th in the solarium of the new wing of the Milwaukee Hospital.

Dr. H. A. Sifton, ex-chief of staff and present honorary chief of staff, reviewed some of the advances made in surgery. Other speakers on the program were Dr. C. A. Evans, chief of staff, and the Reverend H. L. Fritschel, superintendent of the hospital.

The February meeting of the Association was held at the home of Dr. Roland Frederick on February 17th, at which time Dr. G. H. Fellman spoke on "Infant Feeding," and Mr. Gregory Gramling, manager of the Medical Business Bureau, explained the work of the Bureau.

MILWAUKEE OTO-OPHTHALMIC

The February meeting of the Milwaukee-Oto-Ophthalmic Society was held at the Wisconsin Club on Tuesday, February 16th, with a dinner at six-thirty o'clock.

Dr. William F. Moncreiff, Chicago, was the principal speaker, his subject being "Supranuclear Control of the Eye Movements."

WISCONSIN MEDICAL WOMEN

The Wisconsin Medical Women's Society on Monday, February 8th, opened an evening clinic at Mount Sinai Hospital Dispensary, for working women who cannot afford private medical and dental care and who are unable to attend the dispensary clinics during the day. The clinic will be open every Monday evening as long as there is a demand among working women for medical treatment, according to Mr. L. C. Austin, superintendent of Mt. Sinai Hospital.

Milwaukee women physicians who have volunteered their services each week are Drs. Eleänore Cushing-Lippitt, president of the Wisconsin Medical Women's Society, Elsa B. Edelman, Frances Johnson, Gail Moxon, and Ruth Witcpalek, all of whom, except Dr. Witcpalek, are at the present time on the staff of Mt. Sinai dispensary.

This evening clinic will be the only one of its kind in operation in Wisconsin.

THE WOMAN'S AUXILIARY

Mrs. Orvil O'Neal, Ripon, Editor

The Woman's Auxiliary to The Medical Society of Milwaukee County held their regular monthly meeting on Friday, February 12th, at the Hotel Astor at 12:30 P. M.

Dr. Rock Sleyster, a trustee of the American Medical Association, addressed the Auxiliary on the "American Medical Association" and Mr. Theodore Wiprud, executive secretary of The Medical Society of Milwaukee County, spoke on "The Program of the Medical Society of Milwaukee County."

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The following officers were elected at a meeting of the Woman's Auxiliary to the Rock County Medical Society: Mrs. T. O. Nuzum, president; Mrs. H. E. Kasten, Beloit, vice-president; Mrs. T. J. Snodgrass, secretary and treasurer.

Miss Iva Louise Hartman, superintendent of Pinehurst sanatorium gave a talk on the activities of the sanatorium and complimented the auxiliary for its interest. A review of "The Green Pastures" was presented by Dr. Frank Scribner, Congregational church. The February meeting will be held at the Hotel Hilton, Beloit.

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Your national chairman of Press and Publicity urges all Auxiliary women to read the delightful letter from our national President-elect, Mrs. Walter Jackson Freeman, appearing every month in the

Bulletin of the American Medical Association. If your husband has not brought home the recent Bulletins, remind him of that duty.

Mrs. Freeman's letters are inspiring, informing and helpfully suggestive.

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When a book review is desired on the programs of Auxiliary meetings it is gratifying to note what wholesome and fine books are found particularly fitting for the purpose: The Medicine Man in Texas, Magnificent Obsession, Dr. Serocold, Victim and Victor, The Microbe Hunters. The last named might well be incorporated in the most substantial educational program.

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"Some of the Purposes and Workings of the (Georgia) Auxiliary" is the title of a helpfully informing article in the January Georgia Medical Journal, by the President-elect, Mrs. S. T. R. Revell. Georgia's organization is indicated; the usual and the unusual duties of officers are specified; the three standing committees are explained. They are: (1) Public Policy and Legislation, (2) Health Film Library, and (3) Student Loan Fund. At this time the Georgia Auxiliary Loan Fund is supplementing the funds of four high class medical students.

The Georgia State Constitution and its county constitution illustrate the theory of our national president that while there should be certain common objectives and duties, each state and each county have conditions and problems making specially adapted policies desirable.

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The Colorado Hygeia chairman makes a fine plea for Hygeia on the basis that it is an effective way to meet our obligation to provide physical, mental and social help for all children.

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Excellent organization work is going forward in Wisconsin under the inspiration of the President, Mrs. Henry Gramling. The new Auxiliary in Milwaukee held its first meeting December 11, with 156 members present. This is one of several organization achievements.

Among worthwhile programs one is impressed with an example set by a Wisconsin Auxiliary which gave one meeting to a review and discussion of the Minutes and Reports of the Ninth Annual Meeting of the Woman's Auxiliary to the American Medical Association held in Philadelphia June 8–12, 1931. Wouldn't one such program each year in every Auxiliary prove individually and collectively profitable and stimulating; and aid each of us to become more nationally, state, and community minded?

NEWS ITEMS AND PERSONALS

At the annual meeting of the Rock County Cooperative Medical Clinic held at the Monterey Hotel, Janesville, on January 26th the following were named on the board of directors: Dr. Wayne A. Munn, Janesville, president; Dr. A. S. Parker, Clinton, vice-president; Dr. L. J. Friend, Beloit, secretary-treasurer; and Drs. W. T. Clark, F. B. Welch, L. M. Brassington (dentist) of Janesville; W. J. Allen, F. E. Brinkerhoff, and G. E. Cleophas (dentist) of Beloit; J. R. Harvey, Footville; T. L. Vogel, Milton Junction; George W. Belting, Orfordville; J. P. Guilfoyle, Evansville; G. E. Crosley, Milton; and A. T. Shearer, Edgerton.

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Dr. E. L. Schroeder of Shawano sustained severe injuries in an automobile accident. The accident occurred near Shawano when the doctor's car skidded on the slippery road and overturned after striking a tree.

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Dr. Guy C. Waufle, Janesville, spent two weeks in Boston in February where he attended a goiter clinic at Massachusetts General Hospital and took postgraduate work at Harvard Medical School.

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Dr. and Mrs. Gordon Ritchie, Madison, plan to sail on March 31st to spend six months at Wiesbaden, Germany, where Dr. Ritchie will study at the city hospital. Dr. Ritchie is at present instructor in pathology at the Medical School of the University of Wisconsin.

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At the annual meeting of the Sheboygan Clinic staff, the following board of directors was chosen: Dr. Otho A. Fiedler, Dr. Theodore J. Gunther, Dr. H. H. Heiden, Dr. J. P. Zohlen, Dr G. H. Stannard, Dr. C. A. Squire and Dr. John Tasche.

Officers who were elected at a subsequent meeting of the board are as follows: Dr. Otho A. Fiedler, president; Dr. Theodore Gunther, vice-president; Dr. H. H. Heiden, secretary and Dr. J. P. Zohlen, treasurer.

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Dr. H. Paul Johnson, formerly of Minneapolis, has been selected as assistant house physician at Middle River, Douglas County Sanatorium, Hawthorne, Wis. Dr. Johnson was a former member of the Glenlake Sanatorium staff at Minneapolis.

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Dr. Mary V. Dryden, for 33 years on the staff of Battle Creek Sanitarium, Battle Creek, Mich., is now associated with the Madison Sanitarium, Madison.

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Dr. Wellwood N. Nesbit, Madison, spoke on "Colds" before the women's section of the annual Farm and Home week program held in Madison early in February.

Mead Johnson & Company, Evansville, Indiana, announces an award of $15,000 to be given to the investigator or group of investigators producing the most conclusive research on the vitamin A requirements of human beings. Candidates for the award must be pyhsicians or biochemists, residents of the United States or Canada who are not in the employ of any commercial house. Manuscripts must be accepted for publication before December 31, 1934, by a recognized scientific journal. Investigations shall be essentially clinical in nature, although animal experimentation may be employed secondarily. There are no restrictions regarding the source of vitamin A employed in these investigations.

The Committee on Award will consist of eminent authorities who are not connected with Mead Johnson & Company, the names of whom will be announced later.

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Dr. F. X. Pomainville of Wisconsin Rapids was a speaker on the program of a weekly meeting of the Wisconsin Rapids Rotary Club in February. In his talk, Dr. Pomainville advocated the employment of a full time city health physician.

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Dr. L. E. Rauchschwalbe, formerly on the staff of Mendota State Hospital has opened an office in Evansville. He practiced in Milwaukee for some time prior to his position on the State Hospital staff.

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Dr. W. W. Kelly, president of the Green Bay Board of Education, was speaker at a meeting of the Catholic Woman's Club of Green Bay.

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Dr. Byron C. Meacher on February 9th celebrated his 75th birthday anniversary with a dinner party at his home in Portage.

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Dr. Hugh P. Greeley, Madison, is a candidate for election to the Madison Board of Education.

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Speakers on the program of the one-day convention of the Wisconsin Association for the Disabled held at the Hotel Schroeder, Milwaukee, in February, included the following physicians: Dr. C. R. Bardeen, dean of the Medical School, University of Wisconsin; Dr. W. D. Stovall, director of the State Laboratory of Hygiene, and Dr. J. B. MacLaren of Appleton.

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Dr. G. J. Juckem, Sheboygan, and Dr. E. J. Mueller, dentist, have moved into their new offices at 1221 Superior Ave., Sheboygan.

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A new clinic building, which will house the Cantwell-Peterson Clinic of Shawano, is now under construction to be ready for occupancy by June first. The new structure is located on Green Bay street and will be modern in all details.

The seventeenth annual convention of the Catholic Hospital Association of the United States and Canada will be held at Villanova College, Villanova, Pa., June 21st to 24th, 1932.

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Dr. Barton W. Johnson, pathologist at St. Agnes Hospital, Fond du Lac, talked on the use of x-ray before a meeting of the Fond du Lac Kiwanis Club. Dr. Johnson was assisted by Dr. W. H. Folsom in illustrating the talk with x-ray films.

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Dr. R. C. Buerki, Madison, was the principal speaker at a joint meeting of the Neenah and Menasha Rotary clubs at Neenah, January 21st. He also spoke before a meeting of the Appleton Rotary Club at Hotel Northern on February 1st. Dr. Buerki discussed at both meetings the work being done at the State Hospital in behalf of crippled children.

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Dr. R. H. Ware, formerly of West Bend, has accepted a position as staff physician of Mendota State Hospital.

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The regular semi-annual meeting of the State Board of Health officers was held at Madison on January 29th, the following being present: Dr. Gustave Windesheim, Kenosha, president; Dr. Joseph Dean, Madison, vice-president; Dr. C. A. Harper, state health officer, secretary; Dr. J. J. Seelman, Milwaukee; Dr. Mina B. Glasier, Bloomington; Dr. Stephen Cahana, Milwaukee, and Dr. H. H. Ainsworth, Birchwood.

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Dr. and Mrs. E. E. Neff, Madison, spent three weeks in February motoring through the southern states and spending some time in Virginia and Florida.

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Dr. M. L. Whalen, formerly of Duluth, Minn., has opened offices in Bruce, Wisconsin.

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Dr. H. M. Caldwell of Columbus has taken into partnership Dr. E. L. Watson. Dr. Watson is a graduate of the University of Wisconsin Medical School and since his graduation in 1930 had been associated with the Methodist Hospital and the Jackson Clinic, Madison.

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Dr. R. S. Hirsch, formerly associated with the Ludden Clinic, Viroqua, has opened an office of his own in Viroqua.

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During the month of January, 316 persons of which 119 were new patients and 197 were re-treatments, were cared for by the Beloit branch of the Rock County free medical clinic at Municipal Hospital, Beloit.

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Dr. J. J. Kronzer, a graduate of Marquette University Medical School in 1931, was appointed health commissioner and city physician for the city of Oshkosh, succeeding Dr. E. J. Campbell.

Dr. Albert Schloemilch of Portage celebrated his 77th birthday anniversary on February 14th with relatives and friends.

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Dr. Peter B. Rastello, Janesville, presided at the Safety School Sessions held in Janesville on February 16th.

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Dr. W. F. Lorenz, Madison, spoke on "The Treatment of Mental Diseases" before the annual congress on medical education, licensure and hospitals of the American Medical Association in Chicago, in February.

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Dr. J. W. Doughty of Delavan has moved into new offices in the Medical Building at Delavan.

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Dr. W. C. Reincking, Madison, spoke on "Tuberculosis" before a meeting of the Stoughton Rotary Club on February 17th.

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MILWAUKEE

At a meeting of the medical and surgical staff of the Deaconess Hospital on February the 9th, Dr. Chester C. Schneider was elected president and chief, Dr. John B. Matthews, vice-president; Dr. Louis Fuerstenau, head of the surgical staff, and Dr. John H. Reynolds, head of the medical group.

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Dr. C. A. Evans was elected president of staff, Dr. H. B. Hitz, vice-president, and Dr. J. S. Gordon, secretary, at the meeting of the Milwaukee Hospital Staff at its annual meeting on January 29th.

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Mrs. Martha Elizabeth Stratton, mother of Dr. F. A. Stratton, died on February 9th, after an illness of six months. She was 82 years of age. Prior to moving to Wauwatosa, which was the home of Mrs. Stratton at the time of her death, she had resided in West Allis for many years, where she was one of the oldest members of the West Allis Women's Club.

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Dr. Samuel Plahner addressed the Parent-Teacher Association of the Jefferson School, West Allis, on January 4th on the subject of "Do You Understand Your Child?"

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The third of a series of postgraduate medical courses, sponsored by the educational committee of The Medical Society of Milwaukee County, opened February 1st, at the Milwaukee Academy of Medicine, with Dr. A. A. Strauss of Chicago as the principal speaker.

The instructors for this course—"Surgical Diagnosis of the Abdomen"—are as follows: Dr. W. C. F. Witte, Dr. Stanley J. Seeger, Dr. J. L. Yates, Dr. Carl W. Eberbach, Dr. C. M. Echols, Dr. C. A. Evans.

The following members of the Society have enrolled for the course:

Drs. R. E. McDonald, F. W. Mackoy, E. H. Mensing, J. A. Murphy, W. V. Nelson, W. P. O'Malley, E. F. Peterson, J. F. Haug, S. Spilberg, F. J. Stirn, A. L. Suhr, R. A. Toepfer, H. O. Zurheide, S. M. Turkeltaub, P. C. Wagner, R. P. Wiesen, J. C. Zuercher, M. W. Sherwood, H. Rasmussen, Jos. Russell, F. M. Scheele, W. A. Brussock, R. C. Schodron, Geo. Schweitzer, S. J. Silbar, D. C. Ausman, C. J. Becker, J. F. Blair, L. M. Brooks, P. C. Callan, W. J. Carson, P. M. Currer, Urban E. Gebhard, L. T. Gilmer, E. L. Dallwig, S. DeNosoquo, N. F. Dettmann, John Dundon, M. B. Byrnes, Maurice Olsen, P. E. Oberbreckling, J. J. McGovern, B. J. Mainekoff, H. B. Miner, G. W. Neilson, P. J. Niland, J. B. Ozonoff, Albert Popp, E. B. O'Leary, L. P. Stamm, W. L. Stranberg, H. Tabachnick, H. S. Schumacher, Millard Tufts, L. A. Van Ells, H. E. Webb, J. B. Wilets, W. F. Weingart, R. T. Rank, C. C. Reinke, W. A. Ryan, E. Schelble, H. F. Scholz, R. P. Schowalter, J. E. Rueth, John McCabe, Louis Eisenberg, P. J. Eisenberg, E. L. Everts, Roland Frederick, J. W. Fons, P. G. Frey, M. Gabor, E. O. Gertenbach, Wm. Glisch, E. H. Gramling, H. J. Gramling, J. J. Gramling, W. F. Grotjan, E. B. Gute, E. J. Haberland, Bruno Warschauer, H. T. Hansen, C. D. Jurss, A. H. Heidner, A. H. Knudson, H. L. Herschensohn, J. R. Hughes, Edw. Jackson, B. Lando, Jr., R. I. Hiller, J. B. Mathews, E. T. Harrington, A. Kilian, P. M. Kauth, F. J. Korthals, G. Alan Kriz, Bernard Krueger, A. W. Ladewig, Chester Long, A. F. Kusterman, E. C. Heifetz.

After the first session, which is attended by all enrolled, the large group is split up into smaller units and assigned to the instructors. There are three class sessions under the individual instructors. At least one session is held each week until the course is concluded.

The attendance is reported to be excellent and the men enrolled appear most enthusiastic over the work.

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Mr. H. Van Y. Caldwell, executive secretary of the Cleveland Academy of Medicine, was a visitor at the offices of The Medical Society of Milwaukee County on January 25th.

The Cleveland Academy is one of the most progressive county medical societies in the country, and was one of the first to employ a full-time lay executive secretary, which position Mr. Caldwell has filled for the past ten years.

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The Social Medicine and Medical Economics Committee held its first meeting of 1932 in the Mariner Tower on January 28th. The activities of this Committee for the past two years were reviewed, and plans for the ensuing year outlined. Consideration was given to the proposed survey of the medical situation in Milwaukee County, which is to be undertaken by this Committee.

The Health Department Advisory Committee held an important meeting in the Mariner Tower on January 29th, when consideration was given to a complaint received regarding the issuance of prescriptions by school physicians to children having skin diseases. After discussing this situation with this Committee, Dr. John P. Koehler, commissioner of health in Milwaukee, agreed to issue instructions to the effect that all children suffering from ring-worm, scabies, and other skin diseases must be referred to their private physicians for treatment or, if unable to pay for such treatment, to free dispensaries; further, that in compliance with rules already in effect, all diagnoses must be made by physicians. The only exception to these instructions is that school physicians will prescribe for impetigo, if it is determined that children suffering from this disease are unable to pay a private physician for treatment.

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On February 11th, at a meeting of the Maternity Hospital and Dispensary Association Mothers' Club, Dr. J. Victor Bolger spoke on "Care of the Eyes." Dr. J. F. Shimpa addressed the same group on "Care of the Baby," and Dr. M. M. Hipke spoke on "Prenatal, Postnatal and Confinement Care."

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On February 7th, the Milwaukee Hospital, the first Protestant hospital west of the Alleghenies, dedicated a new $425,000 addition. Services, conducted by the Reverend H. L. Fritschel, superintendent of the hospital, were held in the hospital chapel. Reverend Fritschel was assisted by the Reverend August Baetke, pastor of the mother house and chapel. Open house was held from 2 to 5 P. M., with music by the Lake Park Lutheran Church choir.

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Dr. Morris Fishbein, editor of the Journal of the American Medical Association, spoke before the open forum of the Jewish Center in Milwaukee on Sunday, February 7th, on the subject of "Shattering Health Superstitions."

Dr. S. M. Markson presided at the meeting.

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At a meeting sponsored by the Milwaukee Children's Hospital on February 18th, the principal speakers were Dr. Henry Dwight Chapin, former president of the American Pediatric Society, of New York, and Dr. Joseph Brennemann, chief-of-staff of the Children's Memorial Hospital, Chicago.

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On January 22, Dr. Samuel Plahner addressed the County Medical Society of Lansing, Michigan, on "The Cause and Prevention of Neuroses."

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The speakers' bureau of The Medical Society of Milwaukee County was represented during the month of February by the following physicians:

Dr. H. W. Powers addressed the Parent-Teacher Association of St. Judes School on "Character Formation in the Child," on the evening of February 4th. On February 16th, Dr. Powers appeared before the Milwaukee Kindergarten Teachers' Association and gave a repetition of his previous talk.

Dr. D. W. Roberts accepted the invitation of the Milwaukee Woman's Club on February 15th, when he addressed them on "Discovering Ourselves."

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On February 17th, Dr. John O. Dieterle was elected president of the consulting physicians of the Johnston Emergency Hospital. Dr. Louis F. Ruschhaupt was elected vice-president, and Dr. S. H. Lippitt was re-elected secretary-treasurer.

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Restaurant owners in Milwaukee are manifesting keen interest in the plan sponsored by the health council of The Medical Society of Milwaukee County to provide physical examinations for food handlers. Upon completion of the examinations of persons employed at lunch counters, restaurants and tearooms, the institutions employing such persons are given a certificate of good health of employees.

Institutions other than eating places have also shown an interest in this plan and it is expected that they will also participate.

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Dr. and Mrs. Rock Sleyster left early in February for California where they will spend several weeks.

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Mr. Edward M. McMahon, brother of Dr. J. P. McMahon and Dr. Francis B. McMahon, died at Mount Vernon Hospital, New York City, on February 14th, at the age of 47 years.

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The Bureau of Registered Blood Donors is proving to be a valuable agency of The Medical Society of Milwaukee County. It acts as a central bureau, and when Milwaukee hospitals are in need of a donor, a call to the Bureau is promptly and efficiently handled, thus relieving the hospital of the task of locating a donor in an emergency.

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The following health talks, sponsored by the State Board of Health, and delivered by Mr. Theodore Wiprud, executive secretary of The Medical Society of Milwaukee County, will be broadcast over the Milwaukee Journal Station, WTMJ, during the month of March: March 4, "Why We Run Away"; March 11, "Psoriasis—Its Nature and Treatment"; March 18, "Bronchitis"; March 25, "Causes and Prevention of Deafness".

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Dr. E. L. Miloslavich delivered two lectures, on "The Criminological Analysis of Sexual Murders" and on "Interpretation of Gunshot Wounds", at the newly organized Wisconsin Police Training School, at the University of Wisconsin, Madison, during the week of October 25, 1931.

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The Medical Society of Milwaukee County recently directed letters to Milwaukee hospitals inviting them to choose a member from their staffs to represent them in a committee to be formed for the

ANNUAL MEETING PROGRAM

The Committee on Scientific Work requests that those who have suitable material for presentation at the state meeting in September, submit the title with a short abstract of the material to the Chairman, not later than April 30th.

This will permit the program committee to select and arrange the material so that a program of general interest can be built. Address Dr. T. L. Squier, Chairman, 27th Street and Keefe Ave., Milwaukee, Wis.

purpose of making a closer relationship between the hospitals and the medical profession possible, and for the purpose of considering problems which arise from time to time.

The first meeting of this new committee was held on February 17th, and the Milwaukee hospitals were represented as follows:

Columbia, Dr. Stanley J. Seeger; Deaconess, Dr. Chester C. Schneider; St. Joseph's, Dr. J. W. Powers; St. Luke's, Dr. Harvey E. Webb; Milwaukee, Dr. J. S. Gordon; Misericordia, Dr. L. J. Foley; Mount Sinai, Dr. H. B. Podlasky; St. Mary's, Dr. A. J. Weber; Milwaukee General, Dr. Joseph Lettenberger.

Dr. Chester C. Schneider, representing the Deaconess Hospital, was elected Chairman.

Meetings of this Committee will be held regularly, on the 16th of each month.

BIRTHS

A son, Jerome Walter Fons, Jr., to Dr. and Mrs. Jerome Walter Fons, Milwaukee, February 14, 1932.

A daughter to Dr. and Mrs. Weber C. Hermann, West Allis, on February 6th.

ENGAGEMENTS

On February the 14th, the engagement of Dr. Alois F. Kusterman, Milwaukee, and Miss Helen Schwaller, of Burlington, Wisconsin, was announced.

MARRIAGES

Dr. Arthur J. Patek, Jr., son of Dr. A. J. Patek and Miss Mary Marean of Belmont, Massachusetts, were married at the home of the bride on February 17th. Dr. Patek Jr. is a graduate of Harvard University Medical School and is now serving his internship at the Lakeside Hospital in Cleveland.

DEATHS

Dr. J. D. Lindores, Stevens Point, died at his home on January 27th. He had been in ill health for the past four years but had continued his practice until a year ago.

Born in Edinburgh, Scotland in 1859, Dr. Lindores came to this country when a boy. He received his medical training at the American Eclectic Medical College, Cincinnati, from which he graduated in 1887. For a few years, Dr. Lindores practiced in Plover and Plainfield, Wisconsin, and then moved to Stevens Point.

He was a member of Portage County Medical Society, the State Medical Society, and was a fellow of the American Medical Association.

He is survived by his widow.

Dr. F. L. Griswold, Mazomanie, died suddenly at his home on February 11th. While he had been in failing health for several years, he still remained in active practice with the exception of last winter which he spent in Corpus Christi, Texas.

Dr. Griswold was born in Sheboygan County, Oct. 27, 1877, and was a graduate of Milwaukee Medical College in 1905. During the World War he served as first Lieutenant in the Medical Corps, being stationed at Fort Ogelthorpe, Georgia.

He was a member of Dane County Medical Society, the State Medical Society, and the American Medical Association.

He is survived by his widow and two sons, Robert, a senior at University of Wisconsin, and Donald, a junior in high school.

Dr. Louis Schapiro, research worker in tropical diseases in the Orient, a former resident of Milwaukee, died in Bangkok, Siam, on February 5th.

Dr. Schapiro completed his medical training at Harvard University Medical College, and for several years he served in the capacity of government physician in the Philippines.

He had been associated with the Rockefeller Foundation for about twenty years, and had served the foundation as medical director in Costa Rica and in the Canal Zone.

Dr. Schapiro was forty-five years of age.

SOCIETY RECORDS

New Members

A. F. Ruffalo, 522—56th St., Kenosha.
Hugo M. Bachhuber, Athens.
R. E. Graber, Stanley.
Harvey L. Jorgenson, Kenosha.
M. E. Swanton, Appleton.
W. H. Krehl, 204 Broadway, Wisconsin Dells.
F. B. Lansdowne, Kenosha.
W. A. Meilicke, Balsam Lake.
W. B. Walton, 1608 W. National Ave., Milwaukee.

Changes in Address

Victor S. Falk, Stoughton, to Eleventh St., and W. Wis. Ave., Milwaukee.

Resignations

P. P. M. Jorgensen, Kenosha.

» » » CORRESPONDENCE « « «

STATE HOSPITAL COSTS

Portage, Wis., Feb. 4, 1932.

To the Editor,
Wisconsin Medical Journal,
Madison, Wisconsin.
My dear Sir:

I have, for some time, been attempting to find out why so many indigent sick people were sent to the Wisconsin General Hospital when adequate facilities are available in our own community. Believing that the reason must be the price involved, I have procured from Dr. Buerki the cost to state and county of 1,000 consecutive cases (which means major and minor cases) and from St. Savior's hospital in Portage the cost to the patient (which was the amount charged whether paid or not) of 1,000 consecutive cases. This should give us a fair estimate of the comparative costs per case.

Dr. Buerki's statement shows $84,300.00 for the last 1,000 cases. This amount was billed to the state and the state bills one-half of that amount to the counties from which the patients come, or $42,150.00 for 1000 cases or an average of $42.15 per case. He also estimates that the counties pay transportation to and from Madison for 15 per cent of all cases. The one-half paid by the state comes out of the county's other pocket through taxes, so the county is ultimately paying the entire amount.

To this must be added the interest on $1,250,000.00, the cost of erecting the Wisconsin General Hospital, not including recent equipment. Summarized, this means that the counties are paying

Directly	$42.15
Indirectly through taxes to state	42.15
Interest at 3% on $1,250,000.00	11.10
A total of	$95.40

St. Savior's statement for the last 1,000 consecutive cases is today submitted as $25,138.40 or a total per case of $25.13. These figures show that it costs approximately $70.30 more to care for our poor in the state hospital than it would if done locally.

Possibly these figures do not surprise the readers of this article but they surely did surprise me. I felt that it was costing more to send cases to Madison, but I had no idea it was costing as much as these figures show.

This, however, is only one more example of State or Government management compared with private management, and it shows me, and I hope it shows you, as Otho A. Fiedler states, that it is unfair to the present existent hospitals built and equipped to take care of the people in the area in which they exist. It deprives them of a legitimate clientele and, since few of such institutions are at present self-sustaining, it will further reduce their patronage and hence increase the cost of hospital care to the general public.

It is unfair to the physician since it obliges him to pay by taxation for services which he is prepared to render.

It is unfair to the taxpayer as a whole because they have not been informed that it costs them $70.30 more on the average for every case sent to the Wisconsin General Hospital.

Last year 3,397 cases were cared for at the Wisconsin General Hospital, which makes a total of $238,809 more than it would have cost to care for that many cases in their local community hospitals. Regardless of what the University officials say, this is a direct tax burden because "special sources" only make up a part of the general fund and all above amounts raised by "special sources" is a direct tax assessment.

But regardless of that quibble, the money raised from "special sources" comes indirectly from the consumer and that means the taxpayer.

ARTHUR J. BATTY, M. D.

PRIVILEGED COMMUNICATIONS AND HOSPITAL RECORDS

Madison, Wisconsin, February 12, 1932.

Mr. J. G. Crownhart,
State Medical Society,
Madison, Wisconsin.
Dear Mr. Crownhart:

You referred to us a letter from a member of your Society in which he states that it is the policy of certain hospitals in his community to make a record concerning the details of accident cases brought in to them, particularly as to time, place, nature, and parties involved. Your member then inquires whether the doctors or hospital attaches could be made to testify relative to such details in the event of a litigation growing out of them and also inquires whether, as a matter of policy, the hospitals would be better serving the interests of the public by keeping such records.

The above statement resolves itself into four questions for purposes of discussion. They are: 1. To what extent are communications between the physician and his patient privileged in civil actions? 2. To what extent does the same rule apply to hospital attaches? 3. To what extent does the same rule apply to hospital records? 4. As a matter of policy should a hospital keep a record of incidental details of accident cases? These four subjects will be treated in the order in which they are outlined above.

1. *To what extent are communications between the physician and his patient privileged in civil actions?*

By statute in Wisconsin, information acquired by a physician or surgeon in attending any patient in a professional character, *necessary to enable him professionally to serve such patient*, may not be disclosed, with certain exceptions which need not be gone into here. See section 325.21, Stats. of 1929.

This section is broadly interpreted in Wisconsin, so that if the physician states that all information obtained was necessary for treatment, the courts will hold it privileged. Thus in the case of *Kenyon vs. Mondovi*, 98 Wis. 50, it appeared that the physician who treated the plaintiff's leg was asked certain questions as to statements said to have been made to him by the patient as to the previous condition of the leg and the circumstances of the injury. The physician stated that all these facts were necessary for him to know in order for him to treat the case intelligently. The court held this information to be privileged, and refused to reverse the lower court's ruling to the same effect.

No Wisconsin case, however, appears to have involved information possessed by a physician which was not necessary to the treatment of the patient. In 40 Cyc. 2385 the general rule in such a case is stated as follows:

"But in order to exclude the testimony of a physician the information which he is called on to disclose must have been necessary in order to enable him to act and treat the patient in his professional capacity; and hence, where the necessary treatment of an injury is clear to a physician, regardless of how it was received, there is no privilege as to statements of the injured person to an attending physician of the circumstances attending or leading up to the injury".

2. *To what extent are communications between the patient and hospital attaches privileged?*

This question has been squarely before the Supreme Court of Wisconsin where it was held that information obtained by an interne, a nurse, or an attendant is not privileged, because they are not legally admitted to practice and are not physicians within the meaning of the statute. See: *Borosich vs. Metropolitan Life Ins. Co.*, 191 Wis. 239, 242.

3. *To what extent does this rule of privilege apply to hospital records?*

Keeping in mind the discussion numbered 1, supra, we may say that if a physician notes privileged information on hospital records, the records come within the purview of section 325.21, Stats. for 1929. This has been expressly so held in Wisconsin in the case of *Mehigan vs. Faber*, 158 Wis. 645, where it was stated on page 648:

"Deceased was a patient at the Wisconsin Tuberculosis Sanatorium for a time. He was examined by Dr. Coon, the superintendent of the institution, when he was admitted and from time to time thereafter, and a record was made of such examinations by the doctor. Defendant sought to introduce the record, but the court excluded it. Dr. Coon testified that the record contained the information that he obtained from the patient for the purpose of treating him as a physician * * * The record was properly ruled out * * *"

That this rule has been adopted in other jurisdictions is illustrated by the following cases:

In *Smart vs. Kansas City*, (Mo.), 105 S. W. 709, involving a personal injury action, the trial court excluded the evidence of one Dr. Frederick who had charge of the records of the city hospital which were required to be kept by the ordinance of the city. The defendant sought to prove the diagnosis of the plaintiff's case as shown by those records. The plaintiff objected on the ground that the entries made were privileged communications between the physician and the patient. The court sustained the plaintiff's contention and recognized the general rule that hospital physicians attending patients at the hospital cannot testify as to what they learned while so attending him, and said that "this being so, it seems that it must follow as a natural sequence that, when the physician subsequently copies that privileged communication upon the records of the hospital, it still remains privileged".

This rule is stated even more broadly in the case of *Cradick vs. John Hancock Mut. Life Ins. Co.*, a 1923 Missouri case reported in 256 S. W. 501, 504. This case involved an action on a life insurance policy. The defendant company sought to show that the policy was obtained by fraud, alleging that the deceased was afflicted with an active stage of tuberculosis at the time the policy was obtained and offered to prove such allegations by introducing hospital records showing that the deceased had been a patient in a certain hospital for treatment of this disease at the time the policy was issued. The court refused to admit the records, saying "those who are the victims of sickness and misfortune, incapable at times of selecting those whom they most desire to treat them, should be, in an exceptional degree, entitled to the protection which law affords them".

But the foregoing cases apply only to those set of facts where the information originally obtained was itself privileged. It seems obvious that many cases would arise—involving both physician and attaches—where the information would not be privileged, and the records, as well as the physician or attaches might be brought into court. There is considerable dispute whether the records may be received in such event as independent evidence of the information which they contain. Wisconsin has not ruled on this point, but the better rule would seem to be that they can be used ony to refresh the memory of the witness. See: *National Life and Accident Ins. Co. vs. Cox*, (Ky.), 192 S. W. 636, and *Baird vs. Reilly*, 92 Fed. 884.

To summarize the discussion of the foregoing three questions and in answer to your member's inquiry, we may state definitely:

1. That hospital records which contain such suggested information on accident cases as the time, place, and nature of the accident and the parties involved may be brought into court, as may the physicians or attaches, for the reason that such information, save in exceptional cases, is not privileged.

2. Where the information is privileged, neither the record nor the testimony of the physician is admissible.

3. The testimony of hospital attaches is admissible even where the information would be privileged in the case of a medical practitioner, for the reason that such persons do not come within the statutory provision which mentions only a "physician or surgeon", with the possible qualification that where an attache obtained his information from a physician or surgeon, and the latter could not disclose it because of its privileged character, neither could the attache's evidence be admitted.

4. The test to determine whether a communication is privileged is whether it was necessary to the professional treatment of the patient.

It should be carefully borne in mind that the privilege afforded by the statute is for the benefit of the patient *and not of the physician.* The patient may waive his privilege, as may his personal representative or the beneficiary of his policy, and where this is done, the physician cannot thereafter refuse to testify. Section 325.21 (4), Stats. of 1929.

4. *Your member inquires whether such a policy as he outlines is best serving the interests of the public.*

In our opinion this practice should be left to the proper police officials who should have charge of the same. A hospital's great service to the public is that of protecting their health—not their law suits. To maintain that service, a hospital must have the trust and confidence of the people, and to that end should not participate in controversies not affecting it. Erroneous impressions received by members of the hospital force may lead to public criticism and by reason thereof to a loss of public respect as well as a loss of public service. To this end we quote from an editorial appearing in the February, 1932, number of the "Colorado Medicine", as follows:

"It seems likely that, if the hospital expects in the future to be able to obtain a worthwhile record from the patient, the institution must establish a reputation for keeping the information contained therein confidential. Otherwise, if the patient feels that anything he might say, which would aid in the diagnosis and treatment of his case, but would be derogatory to him if divulged in a court or given to an insurance company, he will be very prone to omit this data when giving information regarding his past history, and thereby defeat the real purpose of our hospital records.

"Furthermore, a great deal of time is now wasted by hospital employees in copying these hospital records, or in testifying in court regarding them".

Very truly yours,

FRANK W. KUEHL,
by Robert B. Murphy.

RBM/R

New Medford Clinic Hospital Building Opened January 16, 1932

Opened on January 16th, the Medford Clinic Hospital has a normal capacity of 34 beds which can be expanded to about 45 in case of great need. The building is so constructed that a third story can be added to the present two stories and finished basement. A further possibility of the future is the replacement of the old clinic building east of the new structure with a new building attached as is the present structure to the new building.

The new building has 17 rooms for patients, nine of them private rooms with single beds, four of which have baths and one of the wards is equipped with separate bath. Two other rooms contain two beds each, three with three beds each and three with four beds each. The building, 40 ft. by 84 ft. in size, is constructed of brick and haydite, and stands west of the present clinic building, size 40 ft. by 60 ft. and connected with it on all three floors.

The main floor of the new building is made up mainly of patients' rooms, entrance to which is from the sun parlor of the south. The second floor has a sun parlor directly over the one on the first floor, patients' rooms. The building is also equipped with nursery, instrument, and sterilizing room. The basement contains the nurses' dining room, kitchen, x-ray and physiotherapy rooms. The building is also equipped with an electric push button controlled elevator. Both the Clinic and the hospital are owned by Drs. R. C. Nystrum, L. E. Nystrum, and Donald M. Norton of Medford, Wis.

Supreme Court Holds Chiropractors Are Not "Physicians"; Sweeping Decision Over-rules Circuit Court

Declaring that a chiropractor is not a physician even though he treats the sick and that the services of a chiropractor are not the services of a physician under any conditions, the Wisconsin Supreme Court in February rendered a sweeping decision against chiropractors in a case that arose under the workmen's compensation act. The decision reverses the Circuit Court which had held against the Industrial Commission.

The case arose in Green Bay when a city fireman obtained treatments of a chiropractor for an injury received in his line of duty. The Commission refused to allow the claim of the chiropractor and the Circuit Court upheld the chiropractor. This decision was reversed by the Supreme Court, Justice Fowler writing the Court's opinion. Because of its importance, it is printed in full herewith:

"The only point involved is whether the charge of a registered chiropractor for treatment of an employee entitled to compensation under the workmen's compensation act is allowable as an item of his compensation. The Commission held that it is not and disallowed the item. The circuit court reversed the Commission's order and directed its allowance.

"Under the governing statute, sec. 102.09, Stats. 1927, the expense of treatment recoverable is limited to "medical, surgical and hospital treatment * * * or at the option of the employee * * * (under certain circumstances) Christian Science treatment in lieu of medical treatment."

"The learned circuit judge based his reversal upon the idea that chiropractors give medical treatment as that term is defined in ch. 147 of the statutes which is headed "Treatment of the Sick" and governs the practice of medicine and surgery. While it is true that according to that chapter chiropractors do treat the sick and that their treatment is "medical treatment," it does not necessarily follow from this that it is such medical treatment as the workmen's compensation act contemplates. The legislature might give such meaning under the act to the term "medical treatment" as it saw fit, whether it corresponded with the definition of ch. 147 or not. Doubtless we should hold that under the act the term has the same meaning as in ch. 147 unless the act indicates clearly that it uses the term with a different meaning. But we are of opinion that under the act the only medical treatment contemplated is medical treatment administered by a physician; and we are also of opinion that a chiropractor is not a physician as that term is used in the act and in ch. 147.

"Manifestly the statute does not consider Christian Science treatment as medical treatment although it constitutes treatment of the sick and treatment of disease. Such treatment is "in lieu of medical treatment"; therefore it is not medical treatment. The same is true, under the act, of chiropractic treatment. From the act it appears very clearly that the act contemplates that only physicians may give the medical or surgical treatment for which compensation is allowable. By the terms of the act the employee must choose his "attending physician" from the "panel of physicians named by the employer" in the first instance. Failure to maintain a reasonable number of "competent and impartial physicians" and to permit the employee to choose "his attendant (physician) from among them" is a neglect and refusal to furnish medical and surgical "attendance and treatment." The Commission may on hearing permit an employee to select a "physician" not on the employer's panel. In determining the "reasonableness and size of the medical panel" of the employer, the Commission must take into consideration the number "of competent physicians immediately available." All this indicates that it is only physicians for whose attendance the employee may be compensated.

"Under ch. 147 a chiropractor is not a physician, even though he does treat the sick and treat diseases and diagnose. Under that chapter, physicians are licensed to practice medicine; sec. 147.17; while chiropractors receive a "certificate of registration in the basic sciences and a license to practice chiropractic." Sec. 147.23. But "no certificate of registration shall be considered as the equivalent of a license (to practice medicine)." Sec. 147.17. And "no person not possessing a license to practice medicine and surgery, or osteopathy, or osteopathy and surgery under sec. 147.17 shall use or assume the title "doctor" or append to his name the words or letters "doctor," "Dr.", "specialist," "M. D.," or "D. O." Sec. 147.14 (3). Thus these names and letters may be applied only to those who are licensed as physicians to practice medicine and surgery, and conversely those to whom the names and letters may not be applied are not physicians. It is held in *Isaacson v. Wisconsin Casualty Co.* 187 Wis. 25, N. W. , that a chiropractor is not a "legally qualified physician" under the terms of an accident insurance policy, even though he does treat the sick in a restricted way. The conclusion seems to be based upon the fact that, under the statute as it then stood, chiropractors might "practice their profession" without procuring a license, and the term "legally qualified physician" in the policy meant a "licensed physician," but it seems plain that it might as and perhaps more reasonably have been held that a chiropractor was not a phy-

sician at all. The definition of physician first given in Bouvier's Law Dictionary (2 Rawle's 3d Ed. 2586) is: "A person who has received the degree of doctor of medicine." One of the definitions in Webster's Dictionary is "a doctor of medicine." In line with these defintions, and ch. 147, we are of opinion that the word "physician" as used in the compensation act does not include a chiropractor.

"The appellants contend that the 1931 legislature by passing Bill 497, A., which, had it not been vetoed by the Governor, would have expressly put chiropractors on the same footing as practitioners of Christian Science healing under the workmen's compensation act, indicates a legislative understanding or intent that chiropractors are not to be considered as physicians under that act. The suggestion is not without force, although standing alone it might not be controlling. As above stated, Christian Science treatment under the act is not "medical treatment" but "in lieu" of it and chiropractic if on the same basis would not be "medical treatment" within the meaning of the act.

"*By the Court.*—The judgment of the circuit court is reversed with directions to confirm the award of the Industrial Commission."

Building The Public Health Talk (III) Crossing The Interest Deadline

By H. L. EWBANK, Ph. D.
Associate Professor of Speech
University of Wisconsin
Madison

EVERY PHYSICIAN

Every physician is sooner or later called upon to address lay audiences on some phase of the advance of medicine. Whether his address "gets across" is largely dependent upon his ability to prepare and present his subject matter in terms that his audience will grasp, and in ways that will capture the attention.

This is the last of a series of three articles on "Building The Public Health Talk" published in consecutive issues. The Editorial Board is happy to have had the privilege of securing and presenting these articles written particularly for our readers and deserving of their thoughtful study.

Have you ever heard someone say, "I think I could make a good speech if I could just get started"? Have you listened to speakers who wandered around in circles until you thought they were never coming to the real point of the address? Have you spent hours trying to frame an effective beginning for that article you were writing? Then you know why H. A. Overstreet, in his book Influencing Human Behavior, devotes a whole chapter to the psychological problems involved in building the introduction. He says, "There is, in all communication—written or spoken—a certain deadline of interest. If we can cross that deadline we have the world with us—temporarily at least. If we cannot cross it, we may as well retire. The world will have none of us."

How can we cross this deadline? How arouse the interest of our hearers so that they will stop thinking about their own affairs and start listening to what we have to say? These are important questions for, on our ability to answer them, our success or failure as a speaker largely depends. These are also difficult questions. Sometimes even the most skilled speakers fail to catch the attention of their hearers. The following bits of advice, although they do not answer the questions fully, will prove helpful. It is evident that not all of them can be used in every introduction.

(1) *Start with Definite Situations.* "'What seems to be the trouble?' The doctor speaking. He has arrived with his little black bag and is standing by the bedside." Thus Logan Clendening, M. D., begins an article that appeared in a recent issue of the American Magazine. No beating about the bush there. We are given a picture of a doctor in action and are ready to read on to see what happens.

Here are the introductory sentences to Dr. Howard W. Haggard's radio address on Dr. Percival Pott:

"On a cold January day in 1756 there was an accident on Kent Street, Southwark, a suburb of London. Dr. Percival Pott, the fashionable London surgeon, returning from visiting a patient, was thrown from his horse to the rough cobblestone pavement. His foot struck against one of the round stones, his ankle turned sharply sidewise, and in consequence, the joint was dislocated and the smaller of the two bones of his leg

was broken across, some three inches above the ankle. Moreover the fracture was compounded, that is, the end of the bone was forced through the flesh and skin. It was a serious injury, particularly in those days before antiseptic surgery."

Note how clearly and yet how simply the picture is drawn. The details are accurately given, but with an absence of medical terminology. The only term that might not be readily understood by the average listener, i. e. *compound fracture*, is immediately followed by a definition. When I read this introduction recently to the members of one of my classes their interest was caught; their sympathies were aroused; they wanted to know how the story came out. This is the acid test of a good introduction.

(2) *Start with something that makes a difference.* But not all definite situations would make good introductions. Many are so commonplace as to be lacking in interest values; others that seem highly significant to you may have no meaning at all to the lay mind. The introductions quoted above are good because they contain incidents that might happen to any one. We may not be interested in vitamins, or calories, or carbohydrates as such; but we become vitally concerned about them when you speak in terms of the health of our boys and girls. Start, then, with situations that touch somehow the vital interests of the members of your audience.

(3) *Talk directly to your hearers.* Sometimes it is possible to begin by asking a question to which your audience would really like an answer. If the question is well chosen and well phrased, it sets the hearer to thinking on the subject. Perhaps he formulates his own reply. In that case he will follow to see whether his answer and the speaker's agree.

Here are the opening sentences of a public health talk on diet: "Do your children really like spinach? Would you be interested in learning other effective ways of giving them their vitamins?" And here is another example, this time the introduction to a lecture delivered by Professor V. A. Ketcham to an audience of business men:

"Did you ever come back from an unsuccessful conference and say, 'Well, I told them all about it but I could not make them see it'? Or, perhaps you have had an idea which you wanted to have adopted but you have been forced to say, after months of effort, 'I have done my best to get them to see the point but they simply will not see it!' Now, there are seven ways by which you can make other people 'see the point' and by which you can get them to understand and act on your ideas. I call these ways the Seven Doors of the Mind."

(4) *Begin with a direct statement of your purpose.* When your audience already knows who you are, is interested in your subject, and wants to know what you are going to say about it, state your theme and proceed at once to discuss it.

(5) *Begin with a generally accepted idea.* Sometimes, for the sake of variety, one may begin with a general statement that the audience will accept as true and go from that to a statement of the theme. Here are the first sentences of an address on *Health and Education:*

"The world is changing; it always has been changing. But most of the changes escape our attention. We fail to see them because we are adaptable. If the change about us is gradual, we adapt ourselves to the altered surroundings without perceiving the alteration unless we are especially watching for it. It is only when the change is abrupt that it strikes our attention forcibly."

These, to be sure, are only a few of the devices that may be used in getting away to a good start. Others will occur to you as you prepare your speeches and as you observe the work of skilled speakers and writers. We should not leave this subject without mentioning some of the common faults of introductions. Perhaps the most common fault is that they are too long. The speakers wander around in circles instead of starting immediately at the task of arousing interest in the subject. A radio editor recently told me that most of the speeches given over his station would be better if the speakers had begun about the middle of the second page.

How often we are tempted to begin with an apology. "I don't know why I was chosen to make this speech . . . I don't believe I have much to say . . . I am no speaker, but

will just say a few words . . . Since your chairman called me up a day or so ago and asked me to speak, I have had no time for preparation . . ." Of the methods available for killing the interest of your hearers, this is by all odds the most effective. If you have nothing to say, why talk at all? If you are not well prepared, your hearers may find it out for themselves. Why hurt their feelings by suggesting that you did not think them worth preparing for, that anything that occurred to you at the moment would be good enough for them. There may be, and doubtless are, a few occasions where an apology is in order, but they are so few that the amateur might well write at the top of his notes, "*Do not begin with an apology.*"

MAKING SENTENCES THAT TALK DIRECTLY TO YOUR HEARERS

We have continually said that the best style for the ordinary speech is that of dignified conversation. And in the course of these articles we have incidentally given some attention to the problems involved in direct address. The matter is of sufficient importance, however, to merit further discussion. Here are four of the most important devices that can be used to impart the conversational quality to speech style.

(1) *The Use of Personal Pronouns.* Read the Gettysburg Address and you will be surprised at the number of times the pronouns *we, our,* and *us* occur. "Our fathers . . . We are now engaged . . . We have met . . . We have come to dedicate . . . It is altogether fitting and proper that we should do this . . ."

There is an entirely unwarranted prejudice against the use of the pronoun, *I* in speech. Whenever you would use *I* in conversation, use it in your speeches; it should only be avoided when its use seems to be prompted by a spirit of egotism. These sentences from Dr. Clendening's article illustrate the use of *I, you,* and *your* as they would be found in direct address:

"Behind your doctor—so many centuries, so many stories, so many people. I see them crowding around him—a great throng of old ghosts as he walks into the room. When he listens to your heart, there is thin, consumptive Doctor René Theophile Laënnec, of Paris, inventor of the stethoscope, peering over his shoulder. When he taps your chest, another ghost—jolly, music-loving Doctor Leopold Aeunbrugger, of Vienna—smiles in appreciation that his discovery of percussion diagnosis has lived through the years . . . As your doctor dresses surgical stitches, I see behind him the gentle Joseph Lister, father of modern antiseptic surgery. And farther back in the rim mists of the past I see strange medicine men and bent figures digging herbs . . ."

In addition to the use of personal pronouns, these sentences provide a good example of the use of active verbs to give life and movement to a scene. How easily the information about the pioneers in medicine is slipped into the story!

(2) *The Use of Questions.* It is much easier for us in the audience to feel that the speaker is really talking to us if now and then he asks us a question. Of course he usually does not expect us to answer it out loud, but we do answer to ourselves and this makes us feel that the speech is a partnership affair. The speaker is not telling *the world* about this subject; he is talking it over with *us.*

The question almost inevitably calls for the use of personal pronouns. Thus the device becomes doubly effective. Here is a paragraph from an address on *Health and Education,* in which we are asked a series of questions intended to arouse our interest in the subject.

"Are you curious about the romantic past of today's commonplace? If you are, what thoughts are conjured into your mind by the public school? That institution is certainly a commonplace one to all of us. But what a tempestuous past lies behind it, and even now when it seems a stable institution, it changes year by year. Are you conscious of its changes? Do you take part in the movements leading towards better schools? Or has the change been imperceptible to you? What thoughts are brought to your mind by the statement that tomorrow is the opening day of this year's National Education Week and that Tuesday is set aside for the topic of Child Health?"

(Continued on page 212)

PRESS SERVICE OF STATE MEDICAL SOCIETY

No serum does so much for public health as printer's ink

MENTAL ILLNESS

Madison, Wis., Feb. 4—Ten thousand or more people in the state and county hospitals for the insane of Wisconsin are no disgrace to their families, and their illnesses may have been caused much as other sicknesses. Mental diseases actually develop mildly, as in tuberculosis, and early treatment produces the best results, according to the bulletin of the State Medical Society of Wisconsin issued today.

"The more than 10,000 people in the state and county hospitals for the insane are no longer looked upon by the communities as a disgrace," declares the bulletin. "These people are not possessed with the devil as was thought in the olden days. Mental disease is no more blameworthy than physical disease."

In order to sift out the cases that are easily curable, the State of Wisconsin has mental observation hospitals at Oshkosh and Madison where early treatment can be given to the poor. In many cases serious attacks have been prevented because the patient at the beginning of his difficulty was able to secure advice.

"Most physical disorders produce mental symptoms", continues the bulletin, "such as irritability, peevishness, delirium, or depression, and when these occur no one thinks either of disgrace or stigma. In what people call insanity the symptoms are, as a rule, exaggerations of normal behavior or mood. Generally the condition comes on through no direct act of the individual. Why, then, the thought of reproach? Why consider stigma?

"Through education and experience the people have corrected false ideas regarding general hospitals. They no longer dread them but make use of their facilities with increasing frequency and with growing confidence. No one thinks there is odium attached to treatment in a general hospital for surgical operations, or for pneumonia, typhoid fever, or other physical diseases. Why should there be any such thought regarding treatment in a hospital for mental diseases simply because the sickness affects the brain? People now realize that mental and physical diseases are regrettable conditions which should be prevented, and that when they occur, both should be promptly treated and the sufferer afforded every possible assistance, encouragement, and support, and without thought of reproach in either condition.

"False notions of mental disease cause much unhappiness to the families of patients and result in positive harm to the patients themselves, for frequently needed help is not promptly procured. Secrecy and indecision often prevail and valuable time is lost by delay."

"JUST A COLD"

Madison, Wis., Feb. 11—"The epidemic of colds which is sweeping Wisconsin as the result of the changing temperatures could be checked in a large measure if every person were to use proper precautions. Illnesses resulting from colds could be reduced fifty per cent by rest, but most of the colds could be avoided if proper preventive measures were used," the Educational Committee of the State Medical Society of Wisconsin declared in its weekly bulletin issued today.

"Give coughers and sneezers and spray talkers a wide berth," declares the bulletin. "Wash hands before eating or handling food, and don't shake hands with persons who have a cold unless you wash your hands carefully at once."

The bulletin declares that at Cornell and Johns Hopkins Universities, experiments are being made to determine the causes of colds. These investigations have been going on at Johns Hopkins University for the past four years, financed by $210,000 from the Chemical Foundation. Discovery has been made that persons with colds have an ultra-virus. What that ultra-virus really is, whether it is a living matter or a complex chemical, no one yet knows. One thing, however, has been discovered. People with lower vitality contract colds easier. Cornell doctors point out that it becomes the duty of a sick person to avoid others.

"A moist atmosphere will do much to protect, according to the Educational bulletin.

"Everybody wants to protect against colds because it is easier to prevent than it is to cure," continues the bulletin. "But if a cold does come on, there are simple effective steps to take immediately in order to cut it short. These measures have been recommended by many physicians as first aid for the adult who feels a cold 'coming on.'

"There are five things to do early:

1. Go to bed.
2. Keep the diet light.
3. Drink plenty of water.
4. Keep the system open.
5. Remember that pneumonia, fatal in one out of every five cases, frequently develops from the neglected cold. It can be prevented in large numbers of cases if you will take proper care of yourself.

"When a cold starts, 'give up to it' at once. You will save time. And if it progresses with chills, discharges from the nose, and fever, don't wait to call the family doctor. Again it will save time and money. Be careful if it is a child,—many serious diseases start in children with what seems to be 'only a cold'."

ACCIDENTS AND TUBERCULOSIS

Madison, Wis., Feb. 18—The two things that harrass the lives of school children are accidents and tuberculosis. Accidents rank first as the cause of death for children from three to fourteen years of age, and tuberculosis is the most important single death for children of high school age.

"Accidents and tuberculosis are responsible for nearly 27 per cent of the deaths among children between three and fourteen years of age," declared the Educational Bulletin issued by the State Medical Society today.

"A few years ago railroad accidents and industrial accidents were the chief causes of deaths. This has all been changed. During the past twenty years there has been a decline in railroad accidents, and with the general use of safety devices for dangerous machinery and other hazards in connection with places of employment, there has been a slight decrease in the number of industrial accidents.

"What are the causes for the marked increase in the number of deaths? Without question, the automobile is responsible for nearly all of the increase. Automobiles cause more deaths each year than any other one thing, and the number has increased rapidly during recent years. This emphasis on the danger of automobiles tends to overshadow all other hazards and leads parents to feel that their children are perfectly safe when they are in the home instead of on the streets. Unquestionably, the danger to life is much greater on the streets and highways, but, as a matter of fact, the mortality toll from all other accidents combined is more than three times that

(Continued on page 208)

THE JOURNAL BOOK SHELF

Diathermy. Its production and uses in medicine and surgery. By Elkin P. Cumberbatch, M. A., Medical officer in charge, electrical department, St. Bartholomew's Hospital. Second edition, Price $7.00. C. V. Mosby Co., St. Louis, 1928.

An Introduction To The Literature of Vertebrate Zoology. Compiled and edited by Casey A. Wood, M. D., LL. D., Collaborator, Division of Birds, Smithsonian Institute. Oxford University Press, London, 1931.

Health Protection for the Pre-School Child. A national survey of the use of preventive medical and dental service for children under six. A publication of the White House Conference. Price $2.50. The Century Co., 353 Fourth Avenue, New York, N. Y. 1931.

Allergy and Applied Immunology. A handbook for physician and patient on asthma, hay fever, urticaria, eczema, migraine and kindred manifestations of allergy. By Warren T. Vaughan, M. D., Richmond, Va. Illustrated. Price $4.50. C. V. Mosby Co., 3523 Pine Blvd., St. Louis, Mo.

Conquering Arthritis. By H. M. Margolis, M. D. Price $2.00. The Macmillan Company, New York, 1931.

BOOKS RECEIVED FOR REVIEW

Varicose Veins. With special reference to the injection treatment. By H. O. McPheeters, M. D., F. A. C. S., director of the Varicose Vein and Ulcer Clinic, Minneapolis General Hospital; Attending physician New Asbury, Fairview, and Northwestern Hospitals, Minneapolis. Illustrated with 62 halftone and line engravings. Third revised and enlarged edition. Price $4.00. F. A. Davis Company, 1914 Cherry St., Philadelphia, Pa.

Clinical Roentgen Pathology of Thoracic Lesions. By William H. Meyer, M. D., professor of roentgenology in the New York Post-Graduate Medical School of Columbia University. Director of roentgenology in the New York Post-Graduate Hospital. Illustrated with 183 engravings. Price $6.00 net. Lea & Febiger, Philadelphia.

Psychology and Psychiatry in Pediatrics: The Problem. Report of the subcommittee on Psychology and psychiatry, Bronson Crothers, M. D., Chairman. White House Conference on Child Health and Protection. Price $1.50. The Century Co., New York, N. Y.

Body Mechanics: Education and Practice. Report of the subcommittee on orthopedics and body mechanics. Robert B. Osgood, M. D., Chairman, White House Conference on Child Health and Protection. Price $1.50. The Century Co. New York, N. Y.

Electrotherapy and The Elements of Light Therapy. By Richard Kovacs, M. D., clinical professor and director of physical therapy, Polyclinic Medical School and Hospital, New York; visiting physiotherapist, Manhattan and Harlem Valley State Hospitals and West Side Hospital; Consulting physiotherapist, Hackensack Hospital and Mary Immaculate Hospital, Jamaica, New York. Price $6.50. Illustrated with 211 engravings. Lea & Febiger, Philadelphia, 1932.

The Story of Medicine. By Victor Robinson, M. D., professor of History of Medicine, Temple University School of Medicine, Philadelphia. Price $5.00.

BOOK REVIEWS

Any scientific publication reviewed in this column may be obtained for inspection. Orders for such inspection should be directed to the Medical Library Service, 424 N. Charter Street, Madison, Wis.

The Human Voice, Its Care and Development. Leon Felderman, M. D., price $2.50. Henry Holt & Company, One Park Avenue, New York City. In this book the author has grouped a great deal of anatomy, physiology, hygiene and clinical medicine around his main subject, the vocal organs. There is also considerable philosophy, psychology and chatter. To popularize any branch of science without sacrificing directness, accuracy or order is probably too great a task to ask of any man. It is disconcerting to find the names of such authors as Dochez and Vedder misspelled. However, even in the face of these criticisms the book has a good deal of information and common sense advice. It is of interest chiefly to laymen and especially those who are concerned with the care of their voice. W. J. M.

A Doctor of the 1870's and 80's. By William Allen Pusey, sometime president of the American Medical Association and of the American Dermatological Association. Charles C. Thomas, Publisher, Springfield, Ill. 1932.

This is an account of the life of a first class country doctor of two generations ago by his distinguished son, most of whose life has been spent as a metropolitan specialist. The background is rural Kentucky charmingly painted. The personality of the father and his relations to his family and patients are vividly portrayed as no one but a son, who in his youth was made a companion, could reveal them. The adequacy of the country doctor as a physician is evaluated by one thoroughly familiar with modern scientific medicine and the doctor stands the test well. Those whose memory goes back to the times portrayed will find the book of great interest. Those of a younger generation will find it both entertaining and profitable reading. C. R. B.

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Infections of the Kidney. By Meredith F. Campbell, M. D., F. A. C. S., Price $3.00. Harper & Brothers, Publishers, 49 East 33rd St., New York.

This monograph is divided into twelve chapters, and includes forty illustrations. In it all phases of renal infections are discussed. No bibliography is included. It is written in a concise, intelligent manner and brings the subject up to date. It is recommended to any who are interested in the subject of renal infections. I. R. S.

Surgical Pathology of the Disease of Bone. By Arthur E. Hertzler, M. D. In the preface to this book the author states, "There is not, to my knowledge, any book which treats in a comprehensive manner the pathology of the disease of bones. That there is need for such a book is apparent to every teacher of surgery. The only excuse I have to offer for the publishing of such a book is that no one more capable has made any attempt to fill this very obvious need".

The author has had thirty years experience in medical teaching. He has collected a great deal of material. The book is profusely illustrated, scarcely a page being without a picture and a reproduction of an x-ray or a photomicrograph.

The bibliography at the conclusion of each chapter is short, and purposely incomplete. However, such articles to which references are made are quite representative and easily accessible to anyone.

The book is divided into two parts. Part I deals with the diseases of bone. Part II deals with bone tumors. Your reviewer does not like the classification used in part I, for example, Brodie's abscess, non-suppurative periostitis (Garre), spondylitis deformans, Paget's disease and osteitis fibrosa cystica are all placed under the heading of chronic inflammations.

Part II on bone tumors is based largely on the classification of the sarcoma registry. It is, in the opinion of the writer, much the better portion of the book. R. E. B.

Living the Liver Diet. By Elmer A. Miner, M. D., Independence, Kansas. With introduction by William P. Murphy, M. D., instructor in medicine at Harvard Medical School, Boston. Price $1.50. C. V. Mosby Company, St. Louis, Mo. 1931.

This volume is designed expressly for the laity, but has the added virtue of according the busy practitioner a reference source for prescriptions useful in the liver therapy of pernicious anemia. Unfortunately the author has taken for his text the original unmodified Minot-Murphy regimen, which fulfilled most admirably the requirements of the early period of study of the efficacy of diet in pernicious anemia, but which has now largely been discarded as superfluous except for its content of liver. In other words, the very voluminous discussion of the several components of the diet is no longer necessary, since granted a balanced ration patients do very well without reference to the above minutiae, provided the proper amount of liver is exhibited. Furthermore, the recent development of the several extracts as suggested in the concluding paragraphs of the text have rendered the use of whole liver rather obsolete. The conclusions of Ungley and Suzman as to the apparent peculiar virtue of whole liver in the amelioration of cord changes of pernicious anemia, raises the question of the wisdom of discarding this form of therapy in favor of liver extracts and ventriculin; but there is general agreement as to the redundancy of detail which characterized the original Minot-Murphy diet. Perhaps merely the avoidance of too large a fat component in the diet may ultimately constitute the only qualification to the above generalization.

It would appear from a practical standpoint that the text will have a field of usefulness to dietitians or, as indicated above, to patients with pernicious anemia and physicians who desire some latitude in the preparation of an element of diet which is not tasteful to all patients. In the experience of the dietitians at the Wisconsin General Hospital, they assure us that practically all of the recipes are sound and that many of them have been copied for use in this institution. W. S. M.

Female Sex Hormonology. By William P. Graves, A. B., M. D. F. A. C. S., professor of gynecology, at Harvard Medical School; surgeon-in-chief to the Free Hospital for Women and to the Parkway Hospital, Brookline, Massachusetts. 131 pages, with illustrations. Cloth, $3.50. W. B. Saunders Company, Philadelphia.

This book has 98 pages of exceptionally well presented summary of an extraordinarily interesting and active field of investigation. The author has a very good perspective on the different pieces of work which have been reported in the last few years. He presents the study of the hormones which are active in the familiar sex and reproductive mechanism so clearly that any medical student or clinician can readily comprehend what is being discussed.

The attitude taken is conservative, as one would expect from a knowledge of this author. It is, however, fair and essentially up to date at the time of its writing, late in 1931. The bibliography is by no means complete but is well selected and representative. The presentation of the therapeutic results with the new hormone preparations is perhaps too brief and lacking in appreciation of what has already been accomplished.

This book can easily be read in an evening and will be an excellent investment for any one interested in medical or surgical gynecology or for the general practitioner who must increasingly have a knowledge of the disturbances in the menstrual rhythm and who wants to be prepared for better obstetrics. E. L. S.

A Textbook of Clinical Neurology. By Israel S. Wechsler, M. D., professor of clinical neurology, Columbia University, New York; attending neurolo-

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A CERTAIN State Department of Public Health is greatly exercised over the fact that malnutrition among children seems to be *on the increase.*

In the state referred to, many localities are furnishing the school children hot soup at noon. This explains the outburst of the Health Commissioner quoted above. He ends by saying: "Soup has its place . . . but let's give our growing children milk, and lots of it."

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gist, Neurological Institute and The Montefiore hospital, New York. Second edition, revised. Cloth, $7.00 net. W. B. Saunders Co., Philadelphia, 1931.

This textbook has been in use at the medical school of Wisconsin. We feel that it covers in clear cut descriptions the clinical neurology, the important diagnostic methods, as well as the lately introduced syndromes of neurologic entities. Besides giving a comprehensive but practical outline for a neurological examination, the book explains the indications for spinal punctures and the interpretation of the spinal fluid findings. It reports the progress of researches in the epilepsies and of the vegetative nervous system. The chapter on the spinal cord and on the brain describes the various diseases as the result of abnormal anatomical physiological and pathological disturbances. The diagnostic methods, such as encephalography and myelography have been described in detail. The chapter on syphilis of the nervous system covers every fact and clinical manifestations. The illustrations accompanying the text are excellent supporting the clinical descriptions. The chapter on mental mechanism and on neuroses is practical without too much stress on psycho-analytic features. It contains just the things that the student and the practitioner should know.

I consider Wechsler's Text-Book of Clinical Neurology as the best text for students and general practitioners, but for a neurologist it is not comprehensive enough. H. H. R.

MEDICAL LIBRARY SERVICE

Are you puzzled about the medico-legal aspects of that case in which you must testify? Then do as other physicians are doing—consult the Medical Library Service for the personal help which they are prepared to give. The citation of references in medical literature is their specialty, and they will diligently seek the available sources of information for the particular aspect of the case which interests you.

Many physicians are already availing themselves of the library facilities. "Have you a good text on mental diseases?" asks one physician. "I have to appear in a trial here, and want to brush up or better learn what I can before I get into it. Please rush this!" Pneumoconiosis has been a popular bone of contention between the lawyers and doctors of the state. Every few days another call comes for the available literature on this subject. Another man wants the word of "the very highest authority on hernia" to corroborate his testimony in an industrial tangle. Whatever the need is, the library utilizes all of its available sources of reference, and mails the literature at a cost only of postage and wrapping. Medical Library Service, University of Wisconsin, S. M. I. Bldg., Madison, Wisconsin.

PRESS SERVICE

(Continued from page 203)

from automobiles. Accidental poisoning, burns, falls, drowning and firearms cause a surprisingly heavy mortality and much of it occurs in the home among small children.

"Icy walks, platforms and stairways result in many broken bones. Keeping the sidewalks and steps at home or at the factory free from slippery ice is a public duty as well as an indispensable precaution for the family's safety. The hazard of falling ice and icicles is most serious during thaws. Roofs should be watched carefully and ice and snow removed. Icicles should also be removed, particularly over walks and building entrances. Flat roofs should also be watched. If the snow is heavy, an undue strain may be placed on the roof and cause a cave-in.

"Coal stoves in tightly closed rooms, gas heaters without vents, or gas ranges in which the flame has been blown out are other sources of gas asphyxiation. Salamanders in enclosed spaces may generate dangerous quantities of carbon monoxide and there is always the additional danger of oil-soaked clothing becoming ignited.

"Skidding and slipping on icy walks and streets cause a large number of fatal accidents. Special care in the operation of autos during the winter months, especially when the highway is covered with ice is necessary, if serious accidents are to be avoided."

CROUP

Madison, Wis., Feb. 25—Croup is one of the most distressing disturbances to the parents at this time of the year, and one of the most frightening to children. Inhaling warm steam will help relieve the symptoms, the State Medical Society of Wisconsin advised mothers in a special bulletin issued today. Croup is now prevalent in the State, the bulletin declares.

"Although a severe attack of complicated croup is a very exciting experience for every one concerned, with proper care the life of the child is practically never endangered," continues the bulletin. "Unfortunately, the symptoms of catarrhal or spasmodic croup are quite similar to those of laryngeal diphtheria, a disease having a high mortality, and, consequently, it is most important that an early differentiation between the two diseases is made.

"Spasmodic croup, as its name implies, is a disease in which the outstanding nature is spasm of the muscles of the larynx, and attendant interference with the free passage of air through that organ. Ordinarily the spasmodic condition is caused by inflammation of the larynx as part of a 'cold.' In many instances, however, the child may seem perfectly well, or only have the slightest evidences of a 'cold' upon going to bed, and yet will develop an attack of croup later in the night. On the other hand, catarrhal laryngitis alone does not necessarily lead to croup. Some children never have croup even in the presence of very severe catarrhal laryngitis. Others become croupy as the result of the slightest 'cold.' This difference in susceptibility to croup in different children evidently indicates an individual predisposition to the disorder. Age seems to exert considerable influence on its development in that the disease is most frequent between the ages of two and four years. Such factors as enlarged and diseased tonsils and adenoids and nervous disposition also seem to act as predisposing causes. Acute indigestion at times may bring on an attack in susceptible children.

"Treatment of an attack of croup consists in instituting measures which will relax spasm and relieve congestion. After relief from the acute symptoms has been achieved, the use of steam inhalations helps to insure permanent relief for the balance of the night.

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"Inasmuch as repeated attacks of croup are apt to occur on the succeeding nights, treatment directed at the exciting cause, which is usually a 'cold,' should be persisted in for several days or until complete recovery has come about."

LIPODYSTROPHY

(Continued from page 181)

suggested the subcutaneous injection of insulin with 1% novocaine in hypertonic salt solution into the wasted areas. He reports good results in three cases.

CASE REPORT

L. D. American, white female, age 41, married, was admitted to the hospital in September, 1931, with the chief complaint of "swelling of both hips". Essential past history: Before the establishment of the menstrual cycle at 16, patient weighed over 100 pounds. After establishment of menses, the following changes were observed over a period of four to five years: (1) loss in weight of twenty pounds; (2) Gradual thinning of face, and upper trunk, and (3) darkening of skin.

In 1928 there developed a slowly progressing fatty deposit about both hips associated with intermittent localized pain. Simultaneously there was noted occasional abdominal discomfort with frequent diarrhea, clay colored stools, fatty food intolerance and anorexia.

Family history was entirely negative for any endocrine dysfunction. No history of alcoholism, tuberculosis, or syphilis was elicited. The physical examination revealed a small statured white female with a brown, dirty appearing skin which had suggested Addison's disease to one examiner. There was some thinning of the face and upper extremities with the exception of well developed biceps. There was a marked fatty hyperplasia in the pelvic region extending over both hips, "heart shaped" in contour. This hyperplasia consisted of a fatty infiltration and non-discrete lipomas.

Measurements: Height 58 inches; weight 106 pounds; biceps 11 inches (greatest circumference); forearms 7 inches (3 inches below olecranon); chest 28 inches (during expansion); abdomen 30½ inches; hips 39 inches (over heads of trochanters); and legs 12 inches (3 inches below head of fibula).

The physical and neurological examinations were normal except for moderate generalized abdominal pain to palpation and exaggeration of the knee jerks to three plus. There was no evidence of any vegetative dysfunction. Laboratory findings showed normal urine and blood. Negative Wassermann and spinal fluid. Basal metabolic rate (Du Bois) +6, +7, +9, +9. Blood calcium 10.3. Blood sugar 53, N.P.N. 28. Gall bladder and gastro-intestinal series were entirely negative. Scalp biopsy showed presence of some adipose tissue. X-ray of the pelvis was normal. X-ray of skull showed the sella to be unduly small and almost bridged over by lack of normal density at its base posteriorly and by some increase in the calcific deposit over its superior and posterior regions.

During the period of hospitalization, the abdominal complaints subsided. Patient was discharged with a diagnosis of Progressive Lipodystrophy. No treatment was recommended.

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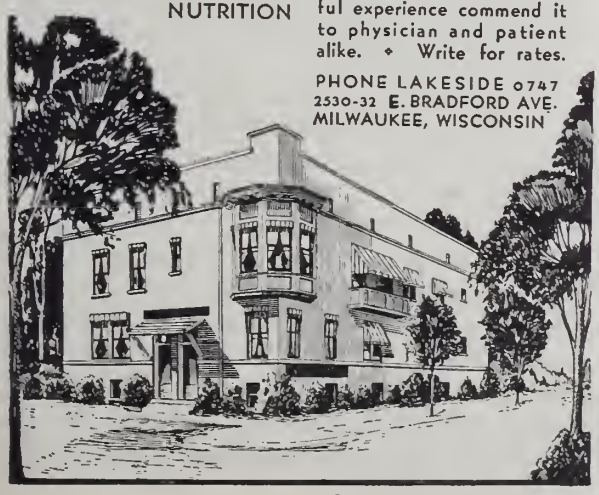

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PUBLIC HEALTH TALK

(Continued from page 202)

(3) *The Use of Direct Suggestions.* Direct suggestion is characterized by the use of what in school we learned to call the imperative mood. "Come with me . . . Let us not forget . . . Think of the sufferings that they endured." In all of these expressions the pronouns are mentally supplied by the listener; the use of such sentences indicates that the speaker is looking at the audience and talking directly to them.

Note the use of direct suggestions in the following paragraph:

"But pause a moment, you who saw the World War in all its horrors, you who sent sons and husbands to its battlefields. Think how much more ghastly its devastations would have been if the Red Cross treaty had not protected the hospital and the wounded man, if the Red Cross nurse and the ambulance had not been there. Think of the Solferino that Henry Dunant saw; think of the Scutari where Florence Nightingale gave her services. Florence Nightingale and Henry Dunant—they were great humanitarians. Now, through the Red Cross, each one of us can take his stand with them. It has made humanitarians of us all."

(4) *The Use of the Vocabulary of Conversation.* All of us recognize a great many words, when we see them in their context on the printed page, that we seldom or never use in our own speaking or writing. When a person uses a great many of these words in his speech we say that he "talks like a book." Nor do such words have as much meaning for the listener as the familiar terms of everyday speech. It follows then that we should constantly strive to express our ideas in words which our hearers use and understand.

Therapeutic — prognosis — etiology—neurological—thrombosis—these words, and all others like them, have no place in your public health talks. They are not found in the vocabulary of the layman; instead of conveying meanings they serve only to mystify. Thorndike's *Teacher's Word Book of Twenty Thousand Words* is an invaluable aid in determining the words that will be understood by audiences at various educational levels.

A WORD ABOUT DELIVERY

Should I write out my speech and attempt to commit it to memory? Should I write it out and read it from the manuscript? Should I speak from an outline? Or should I stand up and talk as the spirit moves me?

The first method demands more time and effort than is often available, although it should be said that most of our greatest speeches have been prepared in just that fashion. The second is unsatisfactory in that few can read from a manuscript and preserve the spontaneity and the communicativeness of conversation. Those of you who attend conventions and listen to the reading of papers have no illusions on this point. The plan of speaking from an outline is better, but, unless you have practiced talking through the outline a number of times, you will probably fail to use the language of your listeners. The only argument for relying on the inspiration of the moment is the hope that somehow you may muddle through. The only person who can make a good speech in this fashion is the one who has thoroughly studied the subject, and whose mind contains memories of speeches previously made that can be called up at short notice.

What, then, is the best method? One answer is that there is no one method that is best for all speakers under all circumstances. Each individual should decide what is best for him. My conviction, derived from some years of experience in preparing speakers for public performances, is that the speaker should usually prepare a manuscript and go over it from the point of view of the suggestions contained in these articles. But it is not necessary that he attempt to memorize the speech verbatim. Instead, he should make an outline of the points made in the manuscript and speak from that. In most cases the sentences that occur to him will be those that are found in the written version, but he will be thinking of the ideas rather than of the choice of words. This method combines the superior style of the written speech with the virtues of extempore delivery.

Now, a word about the delivery of the speech. Look at the people who have come

PHYSICIANS' EXCHANGE

Advertisements for this column must be received by the 25th of the month preceding month of issue. A charge is made of $2.00 for the first appearance of copy occupying 1 inch or less of space and $1.00 for each succeeding insertion of the same copy. Kindly accompany copy with remittance to cover number of insertions desired. Advertisements from members of the State Medical Society will be accepted without charge. Such copy will be taken out after its second publication unless otherwise requested. Where numbers follow advertisements replies should be addressed care Wisconsin Medical Journal.

WANTED—Office assistant position wanted in doctor's office; eight years experience; practical laboratory and x-ray; typing, bookkeeping, secretarial duties. Address Number 863, in care of the Journal. M.

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to hear you—not above them, or past them, but *at* them as you would in conversation. Speak loudly enough that they may hear you. Avoid fidgety movements and mannerisms that detract attention from what you are saying. And, if the next word does not come readily, do not fill up the gap with "uhs" and "ahs". Try to be as pleasant and natural and unaffected in your manner as you are in conversation in the club lounge or at your own fireside.

There is much, much more that might be said. The art of communication is not one that is readily mastered; the person who speaks lucidly and fluently, and seemingly without effort, is reaping the reward of long and continued practice. If you accept invitations to speak in public, you assume the obligation of putting your information in a form that your listeners can follow with pleasure and profit. In this process it is hoped that the suggestions in these articles will be of value.

Report of State Board of Health Annual Meeting

The regular annual meeting of the State Board of Health was held Jan. 29, 1932, at the Board offices in the capitol, with all members present.

Reviewing the 1931 poliomyelitis situation, the director of the Bureau of Communicable Diseases reported to the Board that 723 cases of the disease had been reported in the state during the year, with 49 deaths up to Dec. 1. The estimate was made that the annual fatality rate will be 7%, as compared with a range of from 13.7% to 33% for previous epidemics of poliomyelitis in Wisconsin.

All of last year's reported cases were queried in an effort to secure complete histories, but many lay health officers and some physicians failed to provide the desired data.

Analysis of 262 of the cases showed that of 51 abortive cases not developing paralysis, 47 had been given the serum and four had not. There were 25 cases involving paralysis that later cleared up, of which 13 had been given the serum and 12 had not.

A study of poliomyelitis for the 23 years in which it had existed in Wisconsin prior to 1931 has been made. Dividing this period into halves, the statistics show that the sum total of the mortality in the first half has been a little higher than the mortality in the second half. Apparently, however, case reporting was more efficient in the second half than it was during the first half of the 23-year period.

The larger number of cases in Wisconsin's 1931 poliomyelitis epidemic occurred in the rural districts. The lowest rate is usually in the very northern section of the state. The median rate is usually in the industrial section in the eastern part of the state. The Bureau director stated that the death rate for Milwaukee was low. In the rural districts the people apparently have not developed immunity to the extent that the city people have.

Use of convalescent serum in the treatment of poliomyelitis in Wisconsin will be continued should occasion arise. The Board directed that a supply of approximately 100 doses of the serum be prepared prior to seasonal prevalence.

The consensus of opinion was that intramuscular administration of convalescent serum is accepted as an efficient method. Something over 600 doses of convalescent serum were distributed in 1931. It was moved that the State Health Officer make an effort to find out whether certain medical centers in the state have equipment and such personnel as may be necessary to prepare the convalescent serum.

The Board discussed the prevalence of immunity, particularly with the adult population. It is generally assumed that nearly all adults are immune from poliomyelitis. If the blood is mixed from two parents the prospects are that immune serum will be obtained in 97 or 98% of the combinations.

It appears that a healthy adult is back in condition within 24 to 48 hours after furnishing 500 cc. A second bleeding of 500 cc. within three or four weeks is not harmful in any way. Experiments show that within a year the serum will very completely deteriorate.

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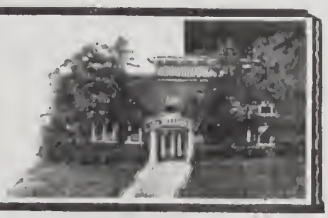

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The Board expressed hearty appreciation of the very fine cooperation extended by the entire medical profession throughout the state, particularly in their reference of convalescent patients to donate blood and in the early and very thorough reporting of cases of poliomyelitis.

INFLUENZA

Possibility of the recurrence of an influenza epidemic during the current year was discussed. Should an epidemic arise, the Board directed the State Health Officer to carry on the program that was put into effect in 1918. During the 1918 epidemic the death rate in Wisconsin from pneumonia, which is a frequent complication of influenza, was 138.7 per 100,000 population, while the death rate in the registration area as a whole from pneumonia during the 1918 epidemic was 286.2 per 100,000 population; or in other words the death rate from pneumonia in Wisconsin during the 1918 epidemic was 147.5 less per 100,000 population than it was in the registration area as a whole.

In presenting his 1931 report, the director of the State, Branch and Cooperative laboratories stated that a total of 130,108 specimens of various classifications had been examined during the year, marking an increase of 17,961 over the 112,147 specimens examined in 1930.

Provisions were made by the 1931 legislature for the creation of one additional state cooperative laboratory to be located at Sheboygan. The State Health Officer reported that the laboratory was equipped and a laboratory director in charge.

Upon receiving the report of the state sanitary engineer, the Board resolved, in response to a query from the Green Bay Metropolitan Sewerage District, that the minimum degree of sewage treatment necessary in the abatement of existing nuisance and pollution situations at Green Bay is efficient sedimentation and disinfection, and that in approval of plans and specifications for a sewage disposal system for the Green Bay Metropolitan Sewerage District at least this degree of treatment will be required.

The city manager of Rhinelander reported that a satisfactory water supply would be turned on January 20th of this year. All the cities of the state now have a safe and satisfactory water supply.

The state plumbing code, as adopted in 1914 and subsequently amended, was repealed by the Board and a new code was formally adopted, a public hearing on the proposed code having been duly scheduled on Jan. 28, 1932.

The new code, in addition to providing for the examining and licensing of plumbers, reestablishes a standard of quality for all plumbing fixtures, regulates methods of installation and provides for supervision of private water supplies and private sewage disposal systems.

Wisconsin's maternal mortality rate for 1931 may fall below 4.4 per thousand live births, it was estimated by the director of the Bureau of Vital Statistics. In recent years the state rate has ranged between 4.9 and 5.8.

DEATH CERTIFICATES

The officers of the State Funeral Directors Association appeared before the Board and asked that the rules adopted by the Board at its last meeting be amended so that the funeral director could remove the body from the institution and perhaps transport it long distances before the death certificate was filed and a burial permit obtained. It was pointed out that such action is in direct violation of the state law, and no amendments were adopted.

Complaints were presented to the Board as to the great difficulty they had at times in having the medical certificate filled out by the attending physician. More serious attention was solicited to devise ways and means of having the death certificate signed by the physician as soon as possible after death occurs.

The term "unprofessional conduct" applicable to the embalmers of the state was discussed. Rules were adopted defining unprofessional conduct. The officers of the State Funeral Directors Association present were in full accord with the rules.

APPOINTMENTS

Miss Olive Graham, R. N., superintendent of Wausau Memorial hospital, was ap-

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Courses in Nursing Courses in nursing are offered in the School of Nursing affiliated with the medical school. A residential course of 32 months is offered in the Wisconsin General Hospital to those who have completed a semester of specified work in the College of Letters and Science. This course leads to a certificate of graduate nurse. A residential course of 27 months is offered to those who have completed three years of college work in specified subjects either in the College of Letters and Science or in the Department of Home Economics. These courses lead to a certificate of graduate nurse and to a B. S. degree.

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pointed to the Committee on Nursing Education, succeeding Miss Stella Ackley, R. N., resigned.

The appointment of Dr. Frances A. Cline as a staff physician of the Bureau of Child Welfare was confirmed by the Board, Dr. Cline succeeding Dr. Eleanor Hutchinson, resigned.

The financial statement for the six months beginning July 1, 1931, was given careful consideration and adopted.

Dr. Windesheim was reelected president and Dr. Dean vice-president of the Board.

NEW COMMITTEE ANNOUNCED

A permanent Committee on Cancer, authorized by the Council at its January meeting, has been appointed by President Otho Fiedler to be headed by Dr. W. D. Stovall of Madison. The Committee, representative of each councilor district, is presently studying the recent cancer survey of the state to report its recommendations to the Spring meeting of the Council. Members of the Committee and their terms follow:

E. H. Spiegelberg, Boscobel, 1932
Frank W. Pope, Racine, 1932
Herman E. Wolf, La Crosse, 1932
H. M. Stang, Eau Claire, 1932
J. F. Wilkinson, Oconomowoc, 1933
G. R. Duer, Marinette, 1933
W. E. Ground, Superior, 1933
F. Gregory Connell, Oshkosh, 1933.
Stanley J. Seeger, Milwaukee, 1934
Paul Doege, Marshfield, 1934
F. Eigenberger, Sheboygan, 1934
W. D. Stovall, Madison, 1934, Chairman

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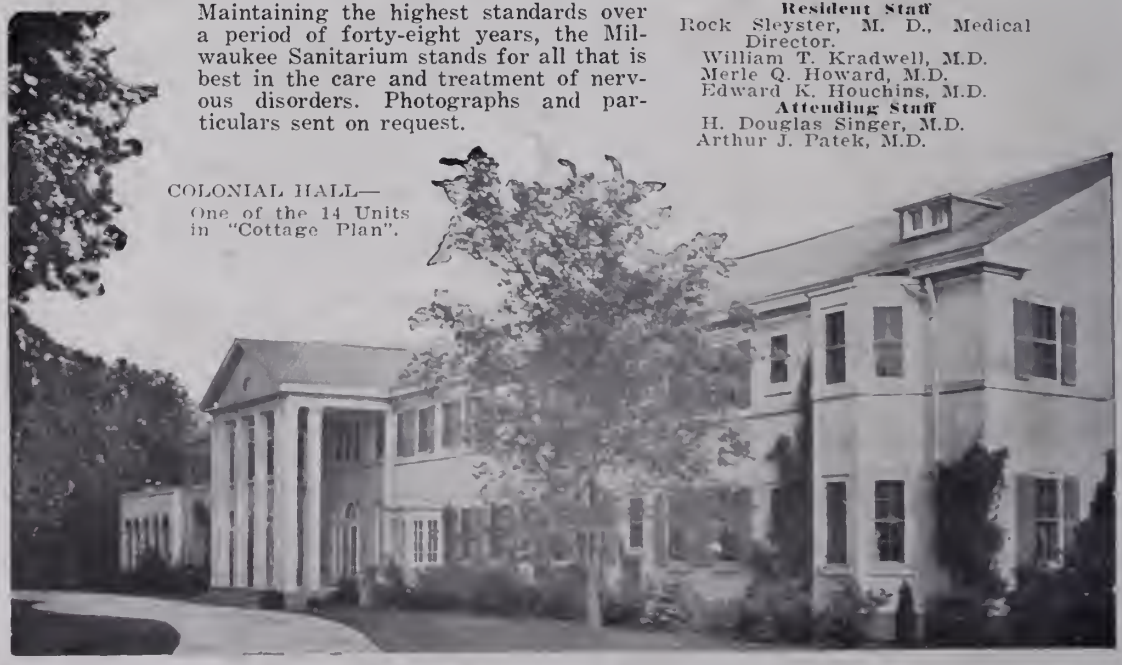

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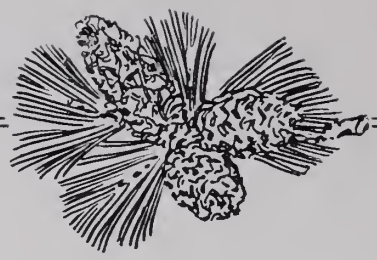

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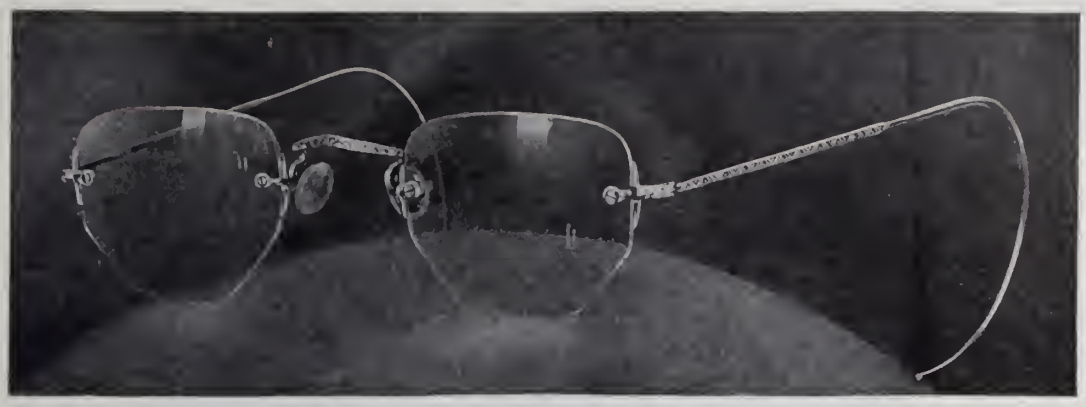

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FRANK C. STUDLEY, M. D.,
Medical Superintendent.

WM. H. STUDLEY, M. D.,
Associate Physician.

The Wisconsin Medical Journal

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Looking Ahead in Tuberculosis

By R. H. STIEHM, M. D.
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Milwaukee

The high tide of reduction in the tuberculosis death rate is probably past. Further progress in reducing the death rate depends largely upon discovering and caring for the tuberculous infected as well as the tuberculous diseased. Even when a patient is detected with a minimal lesion, relatively speaking, it is probable that his tuberculosis has existed for a considerable time. The absence of physical signs does not warrant the conclusion that the disease does not exist. Clinicians have demonstrated the presence of pulmonary change long before symptoms and signs of disease have developed. The patient's tuberculosis is usually in a relatively late stage when a diagnosis is made, and the patient sent to the sanatorium.

This is not to say that our sanatoria are not a strong factor in the fight against tuberculosis. Quite the contrary. Not only do they isolate carriers of infection, but they make recovery more probable, especially for those who enter in an early stage of the disease. But national studies and our experience in Wisconsin both show that from 60% to 90%, averaging at least 70%, of all sanatorium cases enter in a moderately advanced or far advanced stage of the disease. Omitting the childhood type and the "observation" cases who are later discharged as non-tuberculous, the percentage rises even higher. Probably more than any other factor, this advanced stage on entrance limits the benefits of sanatorium treatment. In the second place, from 30% to 60% of discharged patients leave the sanatorium against advice. These percentages are of patients discharged alive. Since close to 20% of the patients in the average sanatorium are discharged dead, it is apparent that only one-fourth to one-half, or even less, remain in the sanatorium long enough to leave with the approval of the attending physician. Third, of the small percentage who leave with the physician's consent, one-third to one-half "reactivate" within five years of their discharge.

These statistics sound discouraging. On analysis, however, they will be seen to result naturally from the characteristics of the disease itself. The victim of an insidious disease like tuberculosis characteristically does not present himself for examination until a late stage and complete recovery then is infrequent. Recovery being slow, and quiescence giving a false sense of security, he leaves the sanatorium before he is cured, with unfortunate results. And since tuberculosis tends to have intermittent periods of quiescence and activity, even among those who do remain until discharge, many subsequently reactivate. In addition, the usual social and financial circumstances connected with each case frequently do not permit the patient to obtain treatment early enough or for a sufficiently long period. These being truths, diagnosis and treatment and intelligent attention to the social problem should be instituted earlier in the disease.

In the past, our concern has been primarily with those suffering with the disease. Future thought and attention will be given to those infected and those not yet infected, that we may discover at an earlier date when infection and disease occur. Admitting these facts, how can this earlier diagnosis best be accomplished?

A positive or negative family history, important as it is, does not tell us with certainty whether or not an individual has been infected. Absence of symptoms and physical signs on examination does not warrant the conclusion that tuberculosis does not ex-

ist. We know that parenchymal changes in the lung occur before symptoms and physical signs of the disease develop. The presence of infection and early disease can usually be determined by the tuberculin test and roentgenograms of the chest. The tuberculin test[1] in most cases indicates the presence of infection and the x-ray will usually reveal the disease in its early stages. Treatment of the patient at this time is likely to be much more successful than at the stage when diagnosis can be made by the presence of physical signs alone. The particular type of treatment required at this early period will be determined only by careful study of these cases.

If we could, then, begin a program of tuberculin testing early in the child's life, with routine tests each year thereafter, we could determine the time, and frequently disclose the source of the infection. Determination of the source would be of great benefit in the fight against the spread of the disease, in that a considerable number of these known carriers could be isolated.

Having determined the presence of infection by the tuberculin test, the occurrence of early disease could usually be detected by serial roentgenograms of the lungs. Such a program would accomplish two desirable ends—the disease would be discovered at a stage where treatment would be most successful, and the individuals in the community who are constantly infecting others would be sought out and more often isolated.

Progress in such a far-reaching program must necessarily be slow, and physicians should first appreciate its necessity. The amazing response of the public in the past twenty-five years, which exceeded many times what the doctor founders of the National Tuberculosis Association anticipated, makes it a safe prediction that the public will meet the medical profession halfway in a program for the diagnosis and treatment of tuberculosis in this earlier stage of the disease.

[1] Tuberculin tests done on University of Wisconsin and Minnesota freshmen show approximately 31% positive reactors. This is in contrast to the belief quite generally held that over 90% show positive reactions at this age period.

Acute Fractures of the Spinal Vertebrae Without Cord Injury; With Report of 100 Cases*

By H. EARLE CONWELL, M. D.

Orthopaedic Clinic, Employees' Hospital of the Tennessee Coal, Iron and R. R. Co., Birmingham, Alabama

A broken back, in times past, generally signified that the patient would develop a marked degree of permanent disability. Today, however, a large percentage of permanent disabilities can be and are prevented by early diagnosis and proper treatment. With the rapidly increasing number of back injuries it brings about a greater demand on the doctor today to be better prepared for treating injuries of this type.

One hundred consecutive and unselected cases of acute fractures of the spinal vertebrae without cord injury are included in this series, of which the total permanent disability averaged 23.5 percent, the oldest patient being 84 years of age and the youngest six years of age.

For a more detailed study you are referred to tables Nos. 1, 2 and 3, and figure 1.

The sixty-four industrial accidents averaged 34.7 percent permanent total disability. Twenty-five of the industrial injuries returned to full duty without any permanent disability. Twenty of the industrial cases returned to light industrial jobs, while twelve cases which averaged 64.5% permanent total disability were not able to return to any industrial work of any kind; these cases, however, are today earning their livelihood at some lighter occupation. Five cases were given one hundred percent permanent total disability. All of these were severe injuries with more than one vertebra

* Presented before 90th Anniversary Meeting, State Medical Society of Wisconsin, Madison, Sept., 1931.

Table Number 1	Cervical	Dorsal	Dorso-Lumbar	Lumbar	Total
Number of Cases	11	22	3	64	100
Vertebrae Involved	14	33	0	79	126
Cases with Single Vertebrae Involvement	8	16	0	56	80
Cases with Multiple Involvements	3 doubles --	4 doubles 3 triples	3 doubles --	4 doubles 3 triples	14 doubles 6 triples
Industrial Accidents	3 males	10 males	3 males	48 males	64 males
Automobile Accidents	4 males 3 females	5 males 4 females	0 0	7 males 3 females	16 males 10 females
	4 open car	7 open car	0	8 open car	19 open car
Airplane Accidents	0	1 male	0	0	1 male
Blimp Accident	0	0	0	1 male	1 male
Gun Shot Wound	0	1 male --	0	-- 1 female	1 male 1 female
Lodge Initiation	1 male	0	0	0	1 male
Civilian Home Accidents	0	1 male --	0	3 males 1 female	4 males 1 female
Total	8 males 3 females	18 males 4 females	3 males --	59 males 5 females	88 males 12 females
Age Averages	28.27	39.89	30.3	37.73	33.29

Table Number 2	Cervical	Dorsal	Dorso-Lumbar	Lumbar	Total
Degree of Severity (See foot note)	2 slight	3 slight	--	5 slight	10 slight
	8 moderate 1 severe	11 moderate 8 severe	2 moderate 1 severe	33 moderate 26 severe	54 moderte 36 severe
Fracture—Dislocations	1	2	0	5	8
Violence How Received	4 direct 7 indirect	13 direct 8 indirect	1 direct 2 indirect	38 direct 26 indirect	56 direct 44 indirect
Anterior Compressions	2	8	1	19	30
Full Correction of Anterior Compression	1	6	1	16	24
Partial Correction of Anterior Compression	1	2	0	3	6
No. Disability in cases Incompletely Corrected	0	1	0	2	3
Necrosis or re-occurrence of Anterior Compression following reduction	0	1	0	2	3
Immediate Diagnosis following injury	11	20	3	63	97
Latent Necrosis following early diagnosis and treatment	1	2	0	3	6

Table Number 2 (Con.)	Cervical	Dorsal	Dorso-Lumbar	Lumbar	Total
Union following Latent Necrosis	1	1	--	1	3
Hibbs' Spinal Fusion	--	1	--	1	2

FOOT-NOTE

The classification of a slight fracture of the spine in this series was one where there was a slight fracture of the spinal vertebra or a fracture with only a slight distortion of the body of the vertebra or a small chip fracture involving the body of the vertebra or its articulation.

A case with a moderate fracture was one where there was only a moderate distortion or comminution of the body of the vertebra with or without a moderate anterior compression fracture.

A case with a severe fracture was one where there was either a fracture-dislocation of the vertebrae or a case with one vertebra broken with a severe anterior compression fracture or a case where there was more than one vertebra broken. Every case of the severe type usually had associated injuries.

Table Number 3	Cervical	Dorsal	Dorso-Lumbar	Lumbar	Total
Cases with Fractured Transverse Process	1	3	0	19	23
Cases with Fractured Spinous Process	1	1	0	3	5
Cases with Fractured Os Calcis.	0	5	0	6 2 bilateral	11 cases 13 fract.
Cases with Fractured Femur	0	1	0	4	5
Cases with Fractured Pelvis	0	2	0	8	10
Cases with Fractured Leg	1	2	0	2	5
Cases with bladder or urethral injury	0	2	0	4	6
Cases with Renal Stones	0	3	0	5	8
Cases with Temporary Thigh Weakness	0	2	1	6	9
Cases with Foot Drop (Temporary)	--	--	--	2	2
Cases with Brachial Plexus Injury	2	1	0	0	3
Cases with Rib Fractures	0	6	0	3	9
Cases without other Fractures or Severe Injury	6	12	0	19	37
Cases with Hypertrophic Arthritis	0	9	0	12	21
Deaths, and their causes	0	2—Both Civilian	0	2—Both Industrial	4
	0	(1) Shock	0	(1) Edema of the lungs	
		(2) Edema of the lungs		(2) Septicemia Rupture Bladder	

fracture being complicated with associated injuries. Two cases died as shown in table 3. The average time off light duty was one year and off full duty was seventeen months.

All of the civilian cases which include automobile accidents and other injuries returned to their original occupation or some productive work of the same character, except the two cases who died (see table 3). None had complete permanent total disability. The average time off light duty was eight months and full duty was twelve months.

CONCLUSIONS

The writer presents the following conclusions after an observation of these cases, hoping that he will not be misinterpreted by some of their apparent abruptness because a further detailed discussion is not possible on account of the allotted space:—

1. First aid, that is, proper splinting, careful handling, treatment for shock, are important. Whenever possible the patient should be transported with the face and body down.

2. Early and thorough physical examinations and roentgenograms—anterior-posterior and especially lateral views in even the least suspicious back injuries should be done.

3. Be suspicious of every case complaining of pain in the back, and never consider a patient with back pain following trauma a malingerer until proper examinations have been made. If the examinations are negative, one's opinion should be reserved for a while until further observations are carried out. Fractures of the vertebrae sometimes result from very slight trauma or negligible injury, especially in the aged.

4. Apparent negative roentgenograms of the spine made immediately following injury sometimes show later on a collapse of the vertebra. These cases are not seen often but should be kept in mind. It is difficult and sometimes impossible to show the presence of a fracture in the posterior portion of the spinal column by roentgenograms.

5. Collapse of a fractured vertebra takes place in certain cases with the best of treatment.

6. Complete reduction is to be desired in anterior compression fractures but is not always possible. Collapse of a fractured vertebra sometimes takes place following a perfect reduction.

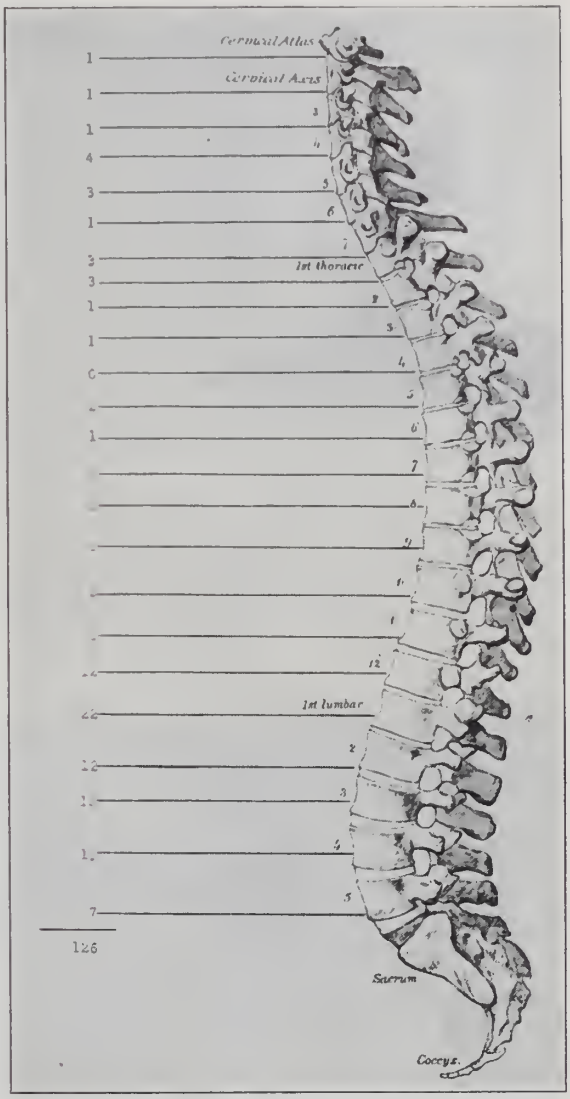

Fig. 1. Sketch showing the distribution of 126 spinal vertebrae fractures in a series of 100 cases of spinal injuries.

7. At no time should an attempt be made at reduction or other treatment carried out on the patient if the general condition does not permit. Always treat the patient first and not the fracture.

8. Excellent functional results are frequently seen in the severe comminuted vertebral fractures (which at first seemed hopeless) because more bone area is present to form callus in the body of the vertebra, or at the articulations of the vertebrae producing a physiological fusion.

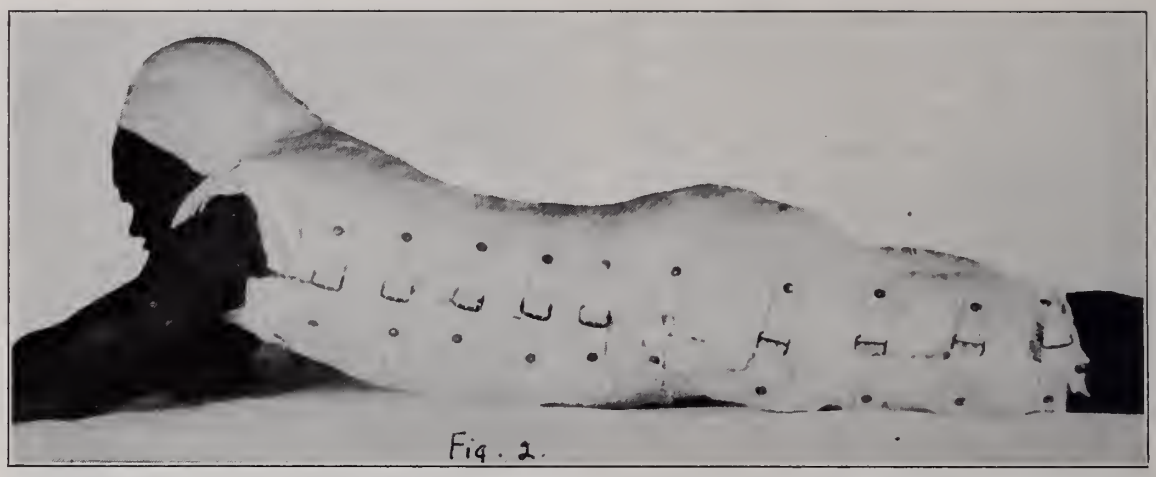

Fig. 2. A composite photograph showing a plaster cast applied, when treating a patient in bed, for fractures involving the spine from the cervical region through the lumbar region. Fractures involving the cervical region while in bed should be fixed from the head down to the hips. Fractures involving the upper dorsal region should have the plaster cast extending from over the shoulders down to the knees. Fractures involving the lumbar region should have the cast extending from the axilla to the knees. In severe fractures or fracture-dislocations of the lumbar region the cast should be applied as in fracture of the dorsal region. The cast can be bivalved in the latter stages of convalescence if so desired. This, however, is not always necessary.

Fig. 3. Author's modification of the Herzmark convex Bradford frame used in reducing anterior compression fractures of the spine. Any amount of convexity of the frame can be accomplished with the aid of a turnbuckle, thereby bringing about any desired hyperextension of the spine. The hyperextension can be secured with any degree of rapidity. Traction and counter-traction are applied to the head and pelvis and the lower extremities if necessary. An anaesthetic can be given but is seldom indicated. In certain fractures of the dorsal and lumbar spine without any anterior compression and where no hyperextension of the spine is desired this frame is very useful in the early stage. The frame in this instance, of course, is kept in full extension, a body cast being applied later.

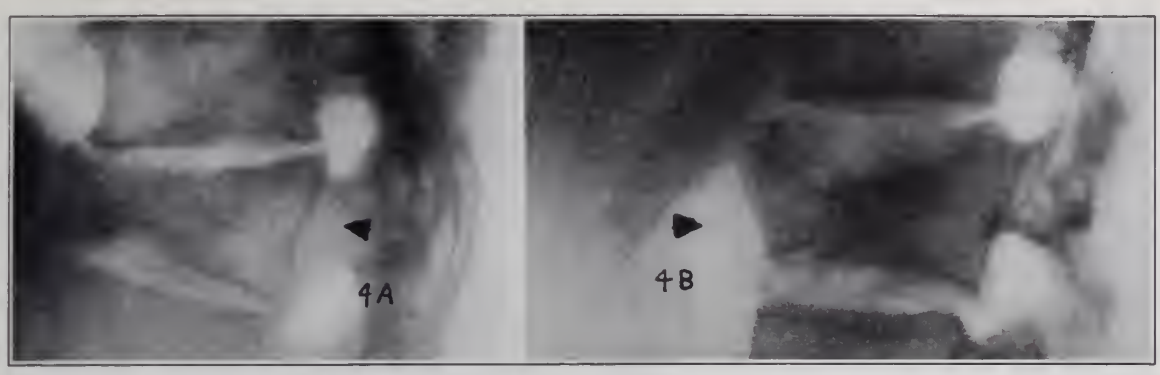

Fig. 4A. Roentgenogram showing a marked anterior compression fracture of the second lumbar vertebra. Patient was placed on the convex Bradford frame with traction to the head and lower extremities while hyperextension of the spine was being accomplished. The results of the treatment in 72 hours following injury is shown in Fig. 4B. Patient remained on the frame with the back in hyperextension for three months. The traction was removed from the lower extremities and the head 20 days following its application, i. e., on date of injury. An ambulatory body cast was worn for four months when roentgenogram showed good callous formation. A Taylor back brace was then applied and worn for six months. Excellent results in sixteen months following injury.

9. Physiological fusion at the articulations of the vertebrae is to be desired and did occur in a large number of cases in this series.

10. Operative fusion is indicated in certain types of spinal vertebrae fractures, especially when roentgenograms show a delayed development of bone union over an average period of time following trauma or in cases with severe persistent pain.

Fig. 5. Type of ambulatory plaster cast to be worn in the convalescent period of fracture of the cervical vertebra. The cast should extend from the front and under the chin and the occiput to the hips. A metal brace can be substituted later if desired. In very slight fractures of the cervical vertebrae usually a Thomas Collar or its equivalent is all that is usually necessary during the whole period of convalescence.

11. Operative fusion does not always relieve pain in the back, but usually should prevent further collapse of the vertebra. Hibbs' spinal fusion is preferred by the author.

12. Osteoarthritis was a common complication in this series in patients passed forty years of age.

13. More than one fractured vertebra is sometimes seen which may be at different levels.

14. The majority of back injuries have

Fig. 6. Results of a Hibbs' spinal fusion in multiple fractures of the lower cervical region. Conservative treatment had been carried out, with a development of a collapse of the cervical vertebrae with marked pain and muscle spasm. Following the operation the necrosis cleared up with much improvement of pain and muscle spasm.

Fig. 7. Type of ambulatory plaster cast which is to be worn in fractures of the dorsal region. A modified Taylor back brace or its equivalent can be used in the later stage of convalescence.

Fig. 8. Roentgenogram showing fractures of the lumbar vertebrae at different levels with a dislocation of the fourth lumbar vertebra.

associated fractures or injuries in other parts of the body.

15. Manipulative reduction under general anesthetic in anterior compression fractures

Fig. 9. Latent collapse of a moderate fracture of the second lumbar vertebra following conservative treatment. Hibbs' spinal fusion done with good results.

Fig. 10. A comminuted fracture of the 12th dorsal vertebra showing a physiological fusion between the 11th and 12th dorsal and first lumbar vertebrae following treatment by the conservative method. Note the abundant callous formation between the vertebrae. Good results in twelve months.

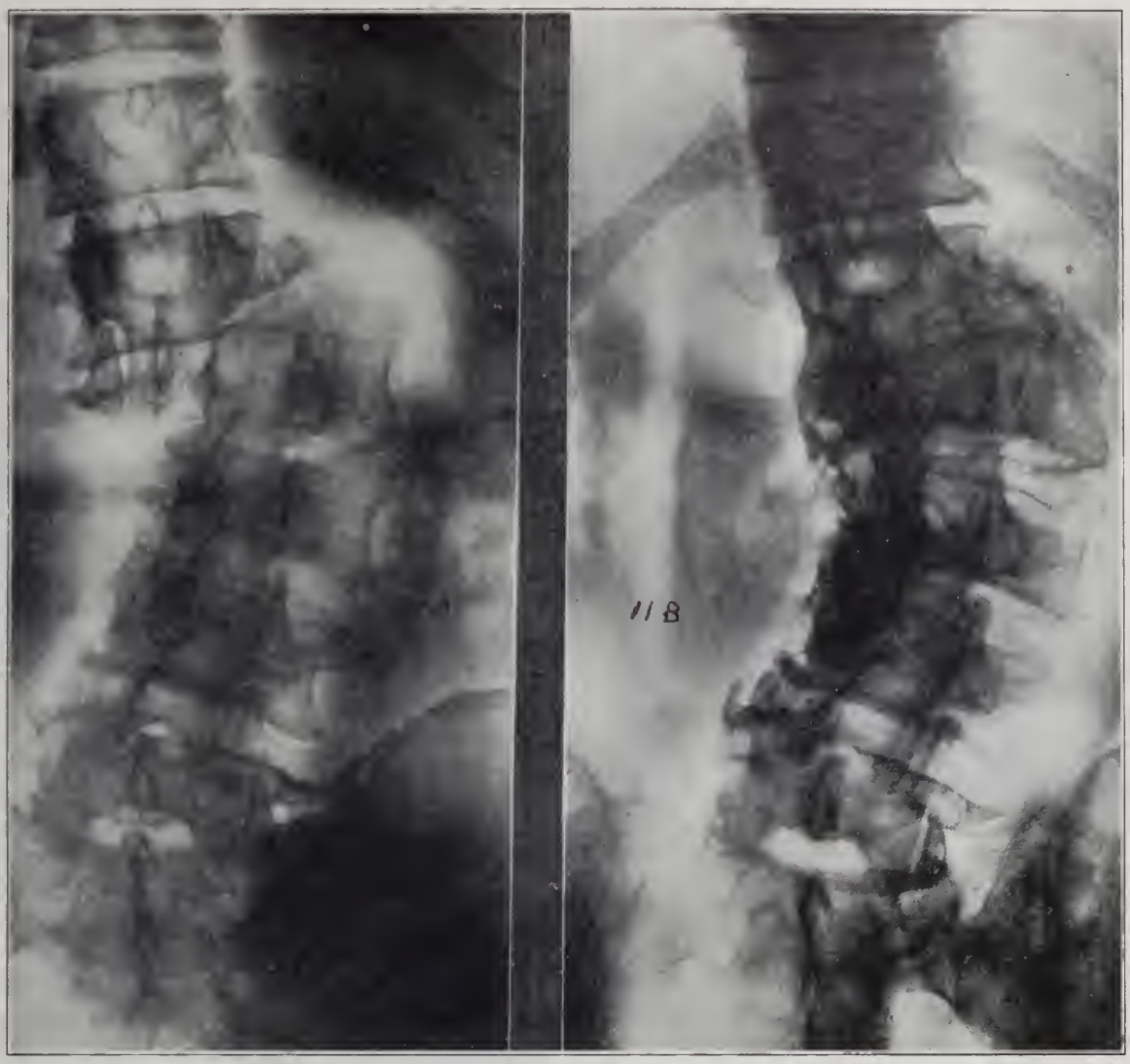

Fig. 11A. A severe fracture-dislocation at the junction of the 1st and 2nd lumbar vertebrae without cord injury. No attempt made at reducing the fracture for fear of injuring the cord. Conservative treatment carried out. Patient was placed on a Bradford frame for ten days with moderate traction to the head and feet but without hyperextension to the back. A plaster cast was then applied extending from over the shoulders to the knees for four months during which time the patient remained in bed. An ambulatory body cast was then applied extending from over the shoulders to the hips and later, after the roentgenogram showed good callous formation, another ambulatory fixation with a Taylor back brace was applied. The latter was worn for one year.

Fig. 11B. Roentgenogram of the case shown in Fig. 11A three years following injury, showing a physiological fusion of the 1st and 2nd lumbar vertebrae.

of the vertebrae is indicated only in certain select cases and should be done only by experienced surgeons.

16. In anterior compressed fractures of the spinal vertebrae the author uses gradual extension of the spine (with or without traction to the head, pelvis and legs) with the aid of a convex Bradford frame (modified Herzmark) with increasing gradual hyperextension of the frame bringing about hyperextension of the spine. The Rogers frame or its equivalent is also recommended. When reduction is accomplished, a plaster body cast is applied, molding the cast to the normal curves of the spine, and then the patient's condition treated as all other uncomplicated fractures of the spinal vertebra. In some instances the patient's entire bed treatment can be carried out on the frame, using plaster body cast only in the ambulatory stage.

17. Generally speaking, fractures of the

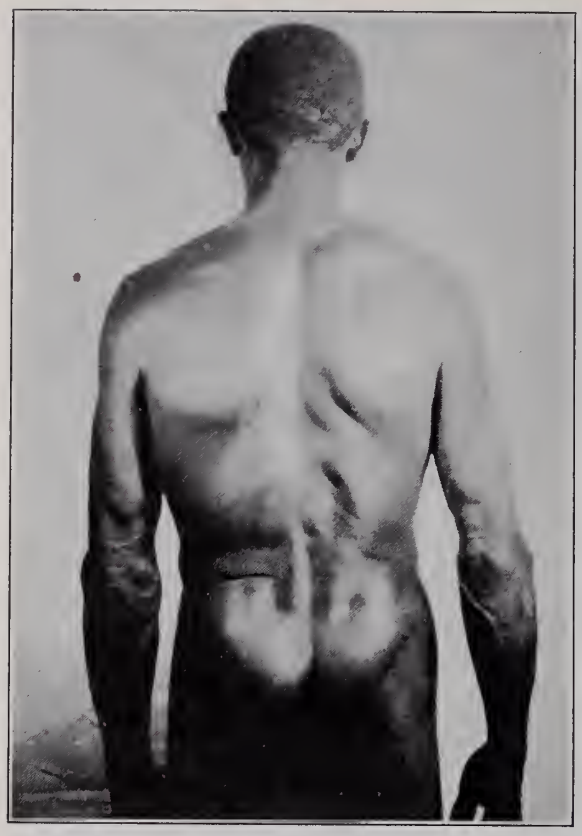

Fig. 12. Photograph of the case shown in Figs. 11A and 11B three years following injury. This patient is earning a livelihood at light work. Has moderate pain in back, no cord symptoms.

cervical vertebrae without displacement should be fixed by an ambulatory body cast extending from around and under the chin and occiput to the hips, while traction is being made on the head. The cast should generally be worn about four months or longer —depending on callus formation. Later a metal brace should be worn until firm union of the fractured vertebra is accomplished. An ambulatory metal brace preferred by the author is the Taylor back brace with metal head piece attachment.

In the *very slight* cervical fractures a Thomas collar or its equivalent is all that is usually necessary.

In cervical vertebra dislocations or fracture-dislocations, early reduction should be done if possible. Reduction should be done with care. Immediate fixation in a plaster cast following reduction should be carried out. Avertin has been used by the author with advantages. In a few cases there is noted a tendency for re-dislocation, which necessitates traction to the chin and occiput in bed for a few days with lateral supports, then later a complete fixation in a plaster cast.

If there is a possibility or a fear of doing damage to the cord by a closed manipulative reduction in those cases with a fracture-dislocation of the cervical vertebrae, traction to the head, chin and occiput with sand bag supports on each side of the head with the patient in bed should be carried out. When reduction is satisfactory and sufficient fixation has taken place to prevent re-dislocation, a plaster cast fixation support is applied.

18. Fractures of the dorsal and lumbar vertebrae should generally be kept in bed ten to twelve weeks, whether on a Bradford frame or a plaster body cast, then in an ambulatory plaster body cast until sufficient callus formation has taken place which averages about three or four months. This is followed by a Taylor back brace or its equivalent. In fractures of the upper dorsal regions the cast should extend over the shoulders. All body plaster casts should be molded to the normal curves of the spine and back.

Dislocations or fracture-dislocations of the dorsal or lumbar spine are generally best treated by slow steady traction and counter-traction. Open reduction is usually indicated in persistent cases. There are cases, however, with fracture-dislocations without cord injury where there is a possibility of doing damage to the cord if any further attempt at reduction, either open or closed, is carried out. These cases are best treated by fixation in plaster body cast in bed as in uncomplicated cases.

Firm fixation in a plaster cast should usually be done immediately following reductions in the dislocated or fracture-dislocations of the dorsal and lumbar spine. When traction and counter-traction are used it should not be removed until one feels confident that no further re-dislocation will take place. Immediate fixation, however, should be applied—usually a plaster body cast before traction is removed.

Fractures of the spine in the very aged or the slight fractures of the spine, especially in the dorsal region, at any age, *usually* demand only a few weeks' rest in bed with fracture boards under the springs and mattress, generally without plaster body cast fixation. A Bradford frame or its equivalent may or may not be used. Some form of ambulatory fixation—a Taylor brace or its equivalent—should be used after the period of bed treatment.

This type of case is frequently overtreated. It must be remembered, however, that the slight fracture is often over-looked, not diagnosed early enough, and not followed up properly with the development of a collapse of the vertebra as the results thereof.

20. Too early weight bearing, sitting or walking should be avoided. This error frequently causes a collapse of the vertebra regardless of the efficiency of the ambulatory support.

21. There is no doubt that when collapse does take place in some spinal vertebra fractures, which originally had good position, and immediate proper treatment, the cause is *an interference with the nutrient blood supply* which occurred at the time of injury.

22. Supports should not be removed until proper assurance by physical examination and roentgenograms showing sufficient callus formation to be present. All supports, however, should be removed as early as possible to prevent muscular wasting and a "mental disability".

23. The psychological element in treating patients with fractures of the spine is important. A thorough understanding by the patient as to his exact condition should be explained by the physician and the patient assured that he is going to get well and will have an excellent chance to get back to his original occupation.

The writer feels that if the above understanding is carried out, especially with the compensation case who generally averages a longer disability than the corresponding injury in a civilian, and the injured man assured that he is going to be given every treatment necessary to obtain a good result, a better co-operation will come about between the doctor and the patient.

Asthma*

By HERMAN T. SCHLEGEL, M. D.
Wausau

A great deal of misinformation and mystery has filled the literature regarding the etiology and treatment of asthma. Over 600 articles have been published, but in spite of the tremendous amount of work done, the profession is helpless in dealing with the problem. This is clearly shown by an editorial in a recent eye, ear, nose and throat journal which says, "It can hardly be gainsaid that the problem of asthma constitutes one of the outstanding challenges to modern medicine. It can be truthfully said, we think, that in no other disease has so little progress been made, amounting indeed to no progress at all. The clinician at large has no more to offer today in the way of permanent relief for this distressing ailment than fifty years ago. And it can be also said, with equal truthfulness, that in no other subject has there been such a welter of wild theorizing and experimenting, with such an absence of rationalization and so little to show for it."

In Europe the same condition exists even to a greater extent. In July, 1929, the Practitioner of London published a symposium of thirteen articles on asthma, written by some of the best known authorities of the world. The Practitioner has rendered a distinct service in bringing together the various unrelated and often conflicting theories regarding asthma and in showing the complete lack of any coherent plans by which the clinical problem can be successfully attacked.

A MORE RATIONAL CONCEPT OF ASTHMA

In 1910 Brodie and Dixon, before the Pathological Society of London, reported the results of 3 years of a most carefully planned

* Presented before 90th Anniversary Meeting, State Medical Society of Wisconsin, Madison, Sept., 1931.

and scientifically complete neuro-anatomical study of experimently produced broncho-spasm. I have not the time at my disposal except to give you a brief resume. Asthma is of nervous origin and a spasm of bronchial muscles is in all instances the cause of asthma. The upper and posterior part of the nasal septum is the only area in which reflex disturbance of the bronchial musculature can be produced.

Dr. Phillip of Miami, Fla., corroborated the phenomena of Dixon and Brodie in the production of asthma, in addition, settling emphatically by laboratory methods what Adams of Glasgow and Haseltine of Chicago claimed clinically. He operated on the intestine of a dog so as to produce a toxemia which was observed both clinically and by the laboratory after the toxemia was well established. Then he exposed the ethmoid area of the animal by trephining the bone and introduced in the nasal cavities a piece of gauze saturated with pus. Within a short time the dog exhibited all the phenomena of broncho-spasm. He removed the gauze, closed the wound and within a few hours the broncho-spasm ceased. The experiments were repeated with different methods of irritating the ethmoids. Broncho-spasm was produced invariably. These investigations have not been published but I am assured they will be at a future date.

In 1913 James Adams of Glasgow, Scotland, published his book "Asthma". Unfortunately the effect of the book was lost during the War. He revised it in 1926. He says in his introductory remarks: "The views expressed in this book are that asthma results from two factors, a toxemia and a lesion in the respiratory tract, usually in the nose." To Adams and Haseltine of Chicago belongs the credit of explaining the close relationship between general toxicosis and vagal irritations in the production of broncho-spasm. Haseltine's idea is that no one can develop broncho-spasm unless he has a clinically demonstrable toxicosis the source of which must be sought and removed and treated by an internist. Irritations in the ethmoid region must be removed.

The newer books on nervous anatomy give us the neuro-anatomical relation between the vagus and the superior maxillary division of the trigeminus which send fibres to the ethmoid area of the nose. Through the sensory root of the trigeminus, by means of collateral neurones, a synaptic relationship is established with the motor neurones of the vagus nuclei which send all impulses to the musculature of the respiratory passages. This synaptic relationship is aptly described by Gardiner in his work "Anatomy of the Central Nervous System." These facts set forth explain anatomically Haseltine's contention that "The reflex arc which makes broncho-spasm possible is formed by the connection between the trigeminal sensory nucleus and the nucleus ambiguus and the dorsal nucleus of the ascending vagus root." He also states that the clinical connection between ethmoid and bronchial musculature is shown by three distinct phenomena. First, in susceptible individuals broncho-spasm is readily induced by mechanical irritation of the ethmoid area. Second, when induced in this way it is promptly relieved by cocainization of the same area and no other. This explains why cocain is one of the most effective agents for temporary relief in broncho-spasm. Third, when broncho-spasm is induced in this manner there is a distinct lateralization of the spasm always on the side on which the irritation is produced. He also points out that in patients showing marked predominance of nasal pathology on one side there is usually definite preponderance of broncho-spasm on the same side.

In addition to the above data, it may be stated that a postmortem performed upon an individual whose death was attributed to asthma, made by Koesler and others showed a striking similarity in the pathology of both the bronchi and ethmoids.

In the light of the above statements and with the experience which I have had in handling asthma, the following deductions safely may be made:

First, practically all patients showing symptoms of the asthma syndrome are in a toxic state. This toxemia is not imaginary but is manifested by certain clinical signs and by definite laboratory findings in the blood and urine. The blood findings are usually a low grade of leucocytosis or in a

few cases leucopenia as low as 3000, also eosinophilia up to 18%. The alkali reserve and urea output are lowered while the uric acid is raised. The refractive index of the serum is raised in all. Increased acidity and specific gravity of the urine are frequently found in the same patients.

By the term asthma syndrome we designate all those manifestations now known to be related to broncho-spasm, whether or not the symptom of broncho-spasm be present. It is very important to recognize that a patient is asthmatic before the stage of broncho-spasm is reached. In this prespastic stage there may be present one or several of the characteristic symptoms such as; urticaria, eczema, erythema, dermatographia, cyclic vomiting, food or other sensitization, angioneurotic oedema, hyperesthetic rhinitis, hay fever etc. The clinical diagnosis may be confirmed by laboratory findings which indicate a toxic state.

It is important to make clear the relation between the toxic state and the condition called "allergy" or "atopic hypersensitiveness." It must not be supposed that the term toxic state and allergy are synonymous. The toxic condition is the factor underlying all the asthmatic manifestations. All allergic states are toxic, but not all toxic states are allergic and the allergy is only one of the symptoms of the toxic state, and, like all the others, tends to disappear with detoxication. The cleaning up of food allergies is a commonplace in our experience, and always without the use of any vaccines or antigens.

Furthermore, broncho-spasm is a reflex phenomenon involving certain definite portions of the nervous system. The unstriped musculature of the bronchioles is supplied by fibres derived from the motor nuclei of the vagus. A peripheral stimulus produces either a normal contraction or a spasm which can be conveyed only by afferent nerves having a deep connection with these nuclei. The sensory portion of the vagus is the only nerve known to have such a connection with the sensory portion of the trigeminus. This is the anatomical explanation for the classical experiment of Brodie and Dixon and of Phillips referred to above. These areas are the same as those clinically known to be especially concerned in broncho-spasm.

PROGNOSIS

The prognosis in asthma can be reduced to the following statement: Asthma can be cured in direct ratio to the completeness and permanency with which two things can be accomplished; either one of which may relieve the broncho-spasm but both are required for a cure. Removal of all causes of toxic absorption and retention by detoxication and removal of irritation from the ethmoid or sphenoid areas. With the correction of these two prominent factors we can, with confidence, predict a marked and often a complete relief. In the prognosis, the age of the patient is of great importance. Children, with striking uniformity, secure prompt and many times dramatic relief without nasal surgery. This relief will be complete and permanent in direct proportion to the intelligence and cooperation of the parents. The prognosis is also affected by the age, severity of the attacks and chronicity. Patients from fifteen years of age to fifty represent a favorable class and offer a favorable prognosis. With broken down, senile changes, damaged hearts or kidneys or perhaps marked emphysema a complete cure may be impossible. By intelligent and careful application of the principles presented, the internist and the rhinologist can now advise the patient with considerable accuracy regarding the amount and permanency of relief which can be secured before treatment is started.

TREATMENT

The treatment which we recommend is one which does not depend upon any formula or procedure that would be useless or dangerous in a non-asthmatic. A definite program is laid out by the internist and the rhinologist and no patients should be accepted for treatment unless willing to carry out the program. The entire management of the patient can be conducted either in a hospital or in the physician's office. Should an operation be necessary the hospital is of course the proper place. If the patient reveals a toxemia sufficient to demand hospital-

ization for the detoxication treatment, the internist devotes his attention to this problem.

The role of the rhinologist is first to examine the septum, especially the upper part and the middle turbinate, for discharge and polypi. It is now possible to inspect the entire ethmoid area including the deep superior ethmoid sulcus. If any abnormality is present it must be corrected. Many asthmatics do not require operation. In any surgical or non-surgical case treatment with Dowling's tampon is imperative. Twenty five years ago J. I. Dowling made some valuable contributions in this particular field. His studies upon animals revealed the fact that a 10% colloidal silver preparation, when placed in contact with the nasal mucous membranes, was rapidly absorbed into the tissues by osmosis. The original Dowling tampon has undergone several modifications. The tampons must be placed in direct contact with the diseased areas. These treatments should be taken daily at first or every other day as the case requires.

CONCLUSION

In conclusion we may say that in the past a great mistake has been made by the rhinologist or by the internist. They have tried to meet the problem single handed. It must be clear that only the closest cooperation between internists and rhinologists can produce satisfactory results.

Multiple Sensitiveness in Hay Fever and Asthma*

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During the past twenty years there have been vast advances made in our knowledge of asthma and hay fever. Quite early, as is generally the case, our small amount of knowledge led to an unwarranted optimism in the treatment of these allergic conditions. As we have gone further and further into a study of allergy and amassed more and more data it has become increasingly evident that our early expectations were the result of ignorance and inexperience, and of late a reaction has set in, a reaction so widespread that the general practitioner of today is extremely skeptical and gloomy about the successful treatment of allergy in its various forms.

So complicated has become the study and treatment of allergic states that the major work is in the hands of a few interested and enthusiastic specialists; a relatively small group, one which could almost be counted on the fingers of his hands. While the mass of practitioners have limited their efforts to the more or less imperfect and routine use of commercial extracts, mainly ragweed, asthma and perennial hay fever still receive scant study and are still treated empirically, with only indifferent success. The reasons for the unsatisfactory results that have been achieved are many.

In the first place, well behaved patients were supposed to react to one foreign substance and after this substance was removed from the environment, or the patient was desensitized against it, he got well. It is now recognized that most patients (94%) have not one, but multiple sensitiveness, which takes various forms. In other words there are primary and secondary factors. The primary factor may be inhaled in the form of pollen, dusts or animal epithelials. Secondary factors may exist in the form of other dusts, foods, bacteria or physical agents—heat, cold and light.

Now if there were only one substance responsible for a person's symptoms and the person reacted by skin test positively to that one substance, matters would still be difficult enough because of the great variety of substances (2,000 I believe now). However, a patient may be sensitive to multiple factors, and when he does not give positive skin tests how is one to proceed especially when one realizes that skin tests are not infallible. A series of negative tests does not mean the patient has not allergy and positive tests to certain substances may mean nothing more than that the patient has an allergic condition and not at all that the allergic condition

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is due to those particular substances to which he gave positive skin reactions.

The primary reason then for unsatisfactory results is the inherent complexity of the conditions.

A second reason is the careless and inefficient handling of cases, imperfect history without proper attention to the time of onset, the age of onset, the place of onset, the course of the disease,—by seasons or years—its association with environment, occupation, work, home, pets, foods and plants. The same careful study of the patient, when free from symptoms, sometimes teaches us more than we can learn when symptoms are present. What was the relation of the onset of disease to other infections or conditions?

In the third place, failure occurs from too much reliance being placed on too few skin tests and too much reliance on skin tests in general, and failure to evaluate tests, both scratch and intradermal tests.

In another important respect our lack of success is the result of failure to identify primary and secondary factors or multiple factors.

In the fifth instance, failure occurs from the routine use of commercial extracts used for desensitization, the doses of which are not adapted to the case in hand.

Lastly, some of the failures are due to our everlasting habit of treating a condition rather than the patient with a condition.

STUDY OF PATIENT

How then may we proceed in the study and care of these patients with hay fever and asthma with multiple sensitiveness?

First, the determination of the hereditary factor by careful questioning in regard not only to hay fever and asthma, but infantile eczema, urticaria, migraine, mucous, colitis and gastro-intestinal upsets of childhood.

Second, a careful history of the patient himself; previous history of possible allergic manifestations—infantile eczema, food idiosyncrasies resulting in later permanent food dislikes or intolerance; age of onset, time (exact date) of onset, place and particular circumstances of onset, relation to disease—pneumonia or other respiratory or upper respiratory disease; time and occurrence of periods of freedom from symptoms—seasonal character—relationship to possible known food factors; a history of patient's contacts with possible factors at work or at home; a study of patient's home and office environment,—flora, fauna, dusts, chemical fumes; type of environmental change which may benefit patient, climatic change, living in city atmosphere, sea trips, etc. Is the condition perennial, seasonal, or sporadic? Does it lap over from one season to another? Don't think that a case of hay fever beginning in July or even on August 1st is a pure ragweed type, even though its major progress may coincide later with the ragweed season. There is a co-seasonal factor in such a case.

Next to the history comes the physical examination which is often less careful and precise than it should be. General bodily states, particularly an endocrine disturbance like hypothyroidism or a highly neurotic state, are important secondary factors and, of course, foci of infection. Though bacterial substances are much less important as causes of asthma and allergic rhinitis than we thought at first, there are too many cases where vaccines specifically immunize or desensitize a patient to leave any doubt about the possibility of there being a specific relationship between asthma and infection. Teeth, tonsils, sinuses, etc., must be ruled out. An eosinophilia of 5 or 6% is always helpful.

Then comes the part of the physical examination that is most tedious and often unsatisfactory,—the specific reactions of foreign proteins applied to the skin. Most workers use the scratch method—a scratch of ⅜ inch and a dry substance or a fresh extract should be applied. The positive reaction must show a wheal and erythema and *pseudopods*. Reactions without pseudopods are generally considered negative. Reaction develops in ten minutes to twenty-four hours. Bacterial proteins generally exhibit delayed reactions, positive after twenty-four hours. Remember that most adult asthmatics are sensitive to dust, most children to foods or dusts.

What are we to do where no positive skin tests tell the story and yet our study con-

vinces us the condition is true bronchial asthma? The history, relief with adrenalin, eosinophilia, etc., are all positive. Perhaps our suspicions rest on some substance. Are we justified in trying to produce asthma by the injection of an extract of that substance when the skin test is negative? Some say that with a syringe of adrenalin ready at hand it is justifiable. I would rather not, in view of some sudden deaths with small doses of protein and many more very alarming reactions.

One thing which is done and will be done more is the placing of the patient in a dust-free room. It should be a thoroughly cleaned, bare room provided with an air filter, and without hair, feathers or wool in the bedding. If in this room, on the patient's usual mixed diet, the patient recovers from asthma, we know it to be an inhaled substance which produces the attacks and can renew our studies on that basis. If no improvement takes places in twelve days we may be dealing with an exhausted patient and a further time should be given for improvement to begin. The filters used in these rooms furnish an atmosphere 95% pollen-free, even filtering 65% of tobacco smoke out of the air. By such careful methods of study a very large percentage of patients will have their multiple sensitivity disclosed.

TREATMENT

What remains is the specific treatment. Where possible this means the removal from the environment of the patient of the offending substance or physical agent responsible for his symptoms.

Where this is not possible, specific desensitization is attempted. In the best clinics of the country the results are as high as 85% successful, more than 60% of success attends the work in all the first class clinics. Further knowledge will raise these percentages.

A few precautions in the use of specific extracts are necessary for success. No initial dose should be large enough to produce a local reaction, nor should subsequent doses produce any constitutional reactions whatsoever. Dosage should be raised steadily and regularly by gradual increase at five to seven-day intervals, or in some clinics by a rapid method—twice daily. Dosage should be given with both primary and secondary factors. Desensitization should never be attempted when patient is having active symptoms.

The average number of injections of the specific extracts seems to be 40 or thereabout. Frequently as high as 60 injections should be given.

The period of desensitization may last only a very short time, ten days sometimes, or only part way through a pollen season, more frequently two months and often six months to a year. A method of prolonging this period is to give or instruct the patient to give himself a weekly dose of the final high dose used in producing the desensitization. If there were 40 doses repeat the 40th dose at weekly intervals for an indefinite period.

Where desensitization is incomplete treatment of asthmatic attack rather than prevention is the rule. Adrenalin is superior to ephedrine and repeated injections are necessary. In such cases the patient or a member of the family should be instructed to give the injection. A patient equipped with a syringe and adrenalin has a sense of security worth everything. Morphine is seldom necessary. Duke has good results with aspirin and whiskey. (large doses)

There are many other precautions which must be observed in the proper handling of the intractable asthmatic. These precautions are learned by meticulous study and patience. There is no man who cannot master the technic if he has the interest and time to do so. Improvement in our results will reward our efforts. It is a difficult and complicated subject which will become simpler when our knowledge is still further extended, and when that time comes our gloom will be replaced by a confident optimism.

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Criminal Confessions Under Narcosis

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Sometimes worthwhile, scientific procedures suffer from notoriety. Popular notions commonly arise from misinformation. The public is easily enamored with beliefs in miracles. This applies at present to the practice of using what is believed to be a mysterious, powerful and miraculous "serum" that will cause a person to "tell the truth". As this procedure, in part at least, is within the field of medicine, physicians should be sufficiently interested and well enough informed to intelligently advise district attorneys and others who may be concerned.

Of course, as every physician knows, there is no such thing as a "truth serum". Upon the other hand, there are certain drugs which will produce a mental state in which consciousness is more or less profoundly affected. While in such a state of altered consciousness, an individual has lost a certain amount of control. He is unable to critically survey his responses to questions. In such a condition his reactions are more or less automatic. The continuity of consciousness, that is, the continued awareness of events that are actually transpiring at the time is disturbed. His ability to associate thoughts, select, inhibit or carefully choose those to be expressed is impaired. Depending upon the drug and the dose used, all degrees of disturbance of consciousness can be produced ranging from a vague sense of slight bewilderment to complete disorientation or unconsciousness. Some drugs produce a delirium with vivid hallucinations, while others induce a state of narcosis without hallucinations. In short, there is no "truth serum" but a state of mind that can be induced by a variety of drugs. In spite of the euphemism of this term which the public has already taken up, it should not be used by the medical profession; and, as far as possible, the medical profession, in its contact with the public, should seek to correct the misinformation that prevails.

ORIGIN

I do not know how this practice of using an induced mental state in dealing with suspected criminals developed. It is a fact that it has struck a popular fancy, as is evident from the publicity it receives. It has a field of usefulness as yet limited but none the less worthwhile. Every clinician has observed states of relative unconsciousness resulting from a variety of causes. The different degrees of delirium associated with infectious diseases, toxemias, intoxications, etc., are examples familiar to any practitioner. It now

seems that the artificial induction of such mental states may be useful. If this continues, it would seem desirable that physicians generally acquaint themselves with the practice so that they may be fully equipped because the whole procedure belongs entirely within the field of medicine.

All physicians are familiar with the use of hypnotics and narcotics to alleviate pain or to so affect consciousness as to render an individual less impressionable and therefore subsequently with a faint or totally absent memory of events that occurred during the period of hypnosis or narcosis. A commonly used drug which received much notoriety during the last two decades, viz., scopolamine, either alone or in combination with morphine, is generally used by those who administer the so-called "truth serum". We have had a long experience in the use of hyoscine or scopolamine. In clinical psychiatry, hyoscine has served for many years as the means to control extreme violence and excitement. The pharmacological action of these powerful drugs is quite familiar to the practicing psychiatrist, particularly if engaged in institutional work. He realizes from experience the variability of response to either of these drugs when used in dosage sufficient to bring about mental manifestations. Hyoscine is a delirifacient. The type of delirium produced depends not only upon the drug used but upon the individual and his peculiarities, past experiences, personality, dreams and wishes, both conscious and unconscious. It is, therefore, difficult even for the experienced clinician to obtain anything like a constant result with these hypnotics unless one aims merely to produce a state of deep unconsciousness. The latter can almost always be accomplished by using an initially large dose of the drug or repeating a smaller dose within short intervals of one hour or less.

If one seeks to produce a mere alteration in the state of consciousness the amount to be used varies greatly among individuals. It may range from 1/50 to 1/200 of a grain. The larger dosage, as is well known, tends to produce the more profound reaction that may amount to coma. Lesser dosage will produce merely degrees of disturbance in consciousness usually associated with vivid hallucinations of sight and hearing and, commonly, excitement as well,—in other words, a delirium. Less drug will produce mild states of bewilderment; in short, the individual is merely hazy—the so-called twilight state. When this latter condition can be induced and maintained for a period of time, one then has the condition of mind that meets somewhat the test of "telling the truth". In the use of the delirifacient for this purpose much care must be exercised by the experimenter to evaluate the results. He must discriminate, if possible, what is the product of fantasy and what of fact. The nearer the subject is to a state of delirium the less usable is the material and information obtained. Those who have listened to the delirious utterances of a sick person can appreciate the unreliability of their disconnected, disassociated utterances. I refer to this at some length in order to emphasize the absolute need of first being experienced with the type of mental disturbances induced by hypnotics and then the additional need of being very critical in arriving at conclusions which, in many instances, would amount to correlating a fantastic delirium with reality. This is no simple problem and even the psycho-analyst with his free use of symbolization and mental mechanisms will hesitate.

Hyoscine hydrobromate is classed as a somnifacient by H. C. Wood.[1] The dose is fixed at from 1/80 to 1/100 of a grain. Mention is made of the frequent idiosyncrasy and excessive susceptibility to its action. This is important because in the procedure under discussion the cases are all untried prior to the time of the examination. One can, therefore, appreciate the difficulty of selecting the proper dose in veiw of this variability of response.

INVESTIGATIVE WORK

We have been particularly interested in practical or medicinal therapy for a number of years. In the course of such work we have critically employed a number of hypnotics in the treatment of various forms of excitement. Observing certain mental states

(1) Therapeutics, Its Principles and Practice by H. C. Wood, 10th Edition p. 189.

which seem to conform to what was required for the test of "telling the truth", we undertook some further investigations and sought especially to compare results obtained from various drugs. From this investigation we conclude that if a delirium can be avoided as a general proposition, the data and information obtained from a subject during a state of narcosis is much more reliable.

We aim to produce a state of mind in which the individual continues to be fairly clear. That is, he is oriented and seemingly aware of his environment, yet his higher faculties are so impaired temporarily that he cannot inhibit automatic reactions to various stimuli. In other words, his responses to questions are reactions well formulated but not subject to any critical censorship. This is the state of mind that we believe might best fit the "truth telling" level.

We found, as might be expected, that in such a condition not only were impressions from without, that is, from the environment, reacted to without censorship, but, also, thoughts arising from within, that is, associations formed on the basis of memories, were likewise uttered without apparent voluntary control. That is, such subjects would talk on, more or less continuously expressing, without any particular emphasis, a whole panorama of views, ideas, experiences and impressions.

We found it difficult to produce this state of mind as a constant reaction with either hyoscine or scopolamine with or without morphine. Upon the other hand, as we became more experienced. with the use of sodium amytal, we found it possible to produce a state of mind that fulfilled the purpose sought and at the same time with the additional advantage that delirium never developed. Another advantage in the use of sodium amytal is the prolonged duration of the state of mind induced during which period it remains unaltered for hours. Finally, with sodium amytal one can very nicely control the entire procedure. When a certain stage has been reached during the administration of the drug one stops and the result from then on remains constant for several hours. In the use of hyoscine or scopolamine one is more or less helpless. When the drug is given you stand by awaiting the result, hoping it will be satisfactory but having no means of recalling the dose administered and unwilling to add if the effect is insufficient.

To use sodium amytal for the purpose under discussion one must, however, follow a certain method of administration and carefully observe certain clinical manifestations. The drug is dissolved in freshly distilled water, using one gram in 20 cc. It is given by intravenous route at the rate of 1 cc per minute. The injection is continued until corneal anesthesia is produced,—usually 10 to 12 cc will be required in an individual weighing 150 pounds. Prior to corneal anesthesia the subject will relax, assume a more comfortable posture and sink into sleep. Frequently it will be observed that before sleep is induced there is a little pharyngeal irritation as evidenced by coughing. Very commonly the subject yawns and stretches, typical of normal reactions prior to sleep. The administration is stopped when the corneal reflex disappears. Within a few minutes following attempts should be made to arouse the patient by either talking, stroking the face or placing a cold, wet cloth over the face. This should be repeated. Usually the patient will make some rather feeble efforts to remove the cloth from the face. One continues to arouse the patient and, as a rule, within four to five minutes the subject will sit up, open his eyes and look about in a somewhat confused manner. The subject is now interrogated. We always begin with some simple questions seeking to disclose his degree of consciousness. In other words, whether he is oriented, recognizes those about him, the place, etc. From this time on the circumstances peculiar to the case should determine the procedure.

Sodium amytal produces a condition in which the subject is voluble. This develops as questions are asked. I have found the most satisfactory results by encouraging the patient to talk, merely introducing the topic and then allowing him to continue without interruption. This is a much more satisfactory procedure than constantly asking questions. Gradually from indifferent topics one approaches more and more the particu-

lar subject concerning which one wants information. With the use of sodium amytal this method of examination can be continued without interruption for a period of two or three hours. We have found no occasion to continue beyond that time, although there was nothing which would have interfered with a more prolonged examination had such been necessary. At the end of this period of time the patient is placed in bed and he sleeps for several hours.

CLINICAL PRECAUTIONS

There are some clinical precautions that must be observed. The subject should have an empty stomach. He should be physically examined before the drug is administered. The blood pressure should be taken. If there is evidence of arterio-sclerosis one must proceed with greater care.

It is interesting to note that there are no disagreeable after effects, either mental or physical. If a proper state has been induced the subject will have a very dim and hazy recollection of what transpired. He knows that he has been questioned but is quite uncertain as to who asked the questions. He knows that he has talked freely but does not recall with any degree of accuracy or detail what he said. He cannot even approximate the time that elapsed during the state of narcosis. He has no recollection of having felt any discomfort, fear, pain or distress of any kind. Instead, he has the impression that he felt good, careless, and, as expressed by some, "like a jag". One subject's memory of the experience was expressed as follows: "I felt good; everything is loose. I could have sat there and said everything."

There is one important difference in the use of hyoscine as compared to sodium amytal which must be mentioned. It deals with the manner in which the desired state of narcosis develops. With hyoscine, usually after fifteen to twenty minutes, the individual becomes drowsy. The effort to elicit information must be started immediately. From that time on one must constantly make efforts to keep the subject from sinking into deeper unconsciousness. One seeks to hold to a level that is reached in the process of transition from normal mental activity to unconsciousness. With sodium amytal, on the other hand, one produces an initial state of unconsciousness, the subject is deeply asleep, corneal anesthesia has developed and complete relaxation is present. In short, he is completely and more or less abruptly disconnected or severed from his environment. After this he is aroused. He returns to a state of partial awareness. In short, there has been a phase of complete separation from the world followed by a phase of partial return. During this latter phase he is in a proper state for examination. From the psychological standpoint I believe that the desired state of mind is more easily obtained following a phase of unconsciousness than when it is sought in the process of losing consciousness.

LEGAL PHASES

Our experience leads us to believe that the most satisfactory results for all concerned are obtained if the subject is treated in the presence of those who represent both sides of any issue that may be involved. That is, in the instance of criminal cases, the District Attorney and his investigator and the counsel or friend of the accused. We believe that at least one such representative should be present. It is our practice that when we have satisfied ourselves that the desired state of mind has been induced and have asked a few preliminary questions in a tone and attitude of friendliness, the others, one at a time, can be invited to direct the examination. We point out to them, however, the desirability of permitting the subject to talk without interruption. We stand by from then on observing the subject's physical and mental condition. That is, we satisfy ourselves that he is in a proper state and that his general condition is good. While we have never had any occasion to do so yet, had there been any efforts to abuse, handle roughly or use harsh methods of any kind we would certainly have objected to any such procedure. By that I mean nothing which simulates what is alleged to be a "third degree method" would have been tolerated.

The advantage of having others present is their knowledge of circumstances that are material to the inquiry. They will be able

to check on the information obtained. But what has been especially valuable in our experience is the absolute conviction and satisfaction of prosecutors when the subject was found to be innocent of the charge. When they are actually present and observe the reaction of the subject, hear the responses made, the whole experiment appears to be most convincing even to those who are charged with the duty of prosecution.

In our experience thus far, as might be expected, the most convincing results have come in cases where an innocent person is suspected or charged with a crime. Our personal experience with guilty offenders is too limited for us to express an opinion as to its value in bringing about a confession of a serious criminal act, such as murder. However, we have found many cases in which lesser crimes unrelated to the one under investigation were very freely confessed. The good that can be served by this procedure is evident in the following cases that will be briefly cited and purposely scanty as to any identifying data because the principal issue is still under investigation.

CASE REPORTS

1. A young farmer was charged with murder. Circumstantial evidence supported the charge. He was wholly unable to meet satisfactorily some of the incriminating facts. These included possession of a gun similar in caliber to that used in the commission of the crime and some other findings which fitted into the whole situation in a logical way warranting suspicion of guilt. Incidentally, the accused feared the public hostility that followed in the wake of this particular shocking murder. At one time it is said that the accused was ready to confess in order to avoid threat of mob violence. This case was examined with the use of sodium amytal in the presence of the District Attorney and the investigator who had been working diligently on the case. Both officers were naturally anxious to obtain a conviction, if possible, and just. In spite of some of the incriminating circumstances they had developed they still were doubtful. The accused agreed to subject himself to an examination under narcosis. The investigator was loaded with facts. After a two-hour examination in which the subject talked freely about everything without reserve and, as was perfectly evident to the laymen present, without any ability to exercise control or discretion, these officers were thoroughly satisfied of the absolute innocence of the accused. This person was about to be indicted and tried. It would have cost him and the County a large amount of money. Even though the outcome had been acquittal, this innocent man would still have remained under a cloud. Subsequent investigation in this case has very conclusively established the innocence of this person.

2. A young man, charged with murder, while in the hands of the police, signed a confession. Later, while in a county jail, he retracted this confession. When he was about to be returned to the police he made another confession which he again retracted. He claimed later that his repeated confessions were made because he feared the police practice of examination and preferred to go to prison for life rather than face such an ordeal. He was not insane nor feeble-minded, although not of any high degree of intelligence. The District Attorney and his aids were at a loss. Some known facts did not support his confession and generally the whole case was confused. This person agreed to the special examination and the District Attorney and sheriff were present. This subject had quite evidently lived with the underworld. His language and slang were typical of the gangster and, among other things, he prided himself on adhering to the code of "not squealing". Later, while under narcosis from sodium amytal, he readily informed us of a jailer who brought "booze" and "dope" to the prisoners. And how the same jailer exacted money for privileges. He told of confessions made by jailmates. Concerning the crime under investigation, he freely related his association with those who actually committed the murder; his own part in the initial plans and that he was to receive a reward or, as he expressed it, was to "cut in" on the "swag". He stated that he did not actually take part in the physical commission of the crime and was not present. He also stated that he never received his share of the proceeds and sometime would square accounts with the "welcher". He identified by description, aliases, addresses, etc., those who did commit the crime according to his own account and he also stated that they had been companions who had served time with him in prison. His own criminal record was related in detail. In this case information was obtained which, I am told, was subsequently used, much of it corroborated, but as yet not to the point of a successful conviction of the guilty persons.

3. Another case of a young man suspected of murder, arrested on some other charge for the purpose of holding him while the case was being investigated. In this case there were some circumstances that warranted a suspicion at least that the one held had either committed the crime or had some knowledge concerning it. This subject agreed to the special examination. The District Attorney, his investigator, the subject's lawyer and another official familiar with some facts were present during the examination. The inquisition lasted over two hours. The subject talked freely, concerning his means of livelihood, which was by crooked gambling, following conventions, and of using all sorts of devices and practices to obtain money illegally. He

related in detail his delinquent and criminal conduct, including a prison sentence. In these accounts the language, profanity and expressions used were typical of that customarily used by the individual in his association with his group. In this case, unknown to us, the subject's lawyer, to satisfy his own curiosity, had planted a test. He told the subject to give a false name if a certain person were asked about. Later, in the course of the examination, this individual was touched upon and the subject gave his correct name but added that he had been told to call him so and so which was, in fact, not his name. This reaction completely satisfied his lawyer that the subject was telling the truth or was unable to maintain a lie. Incidentally, the subject also volunteered the information that his lawyer had told him to go ahead and have a test made if he was innocent but if he were guilty he would not have to submit and under these circumstances his lawyer would get some other attorney to defend him. In this case all concerned were absolutely convinced after the examination that the subject had no knowledge whatever of the crime under investigation and that he was entirely innocent of this charge although not by any means guiltless of numerous other crimes and misdemeanors.

ETHICAL STANDARDS

This latter revelation suggests the need of some ethical standards of using this method of seeking information. I personally believe that, though guilty of some unrelated crime disclosed by a confession in the procedure of seeking information on another crime and taking into consideration the person's willingness to submit to what must be considered to be an unusual form of examination, because of suspicion or accusation, he should not be called upon to defend himself against such other charges, at least it seems to me that this should apply in relatively minor crimes or offenses that may be confessed to in the course of such an examination. There are other ethical questions to be considered which the legal profession must answer. In fact, I believe the whole procedure should be weighed and receive a judicial opinion. Thus far when the procedure has been used in the pursuit of criminal investigations I have made it a practice to carefully inform the subject of what is going to be done, obtain his consent after he has been fully informed, explaining to him his helpless condition but also assuring him that there was no hazard so far as his health was concerned.

I believe that others should be present, and I like least of all to act as the inquisitor. It seems to me that the physician might best act only as a medical person who induces a mental state and then stands by protecting the patient's mental and physical welfare. This whole practice places the medical profession in a rather uncomfortable position because through his medical knowledge and efforts a person is rendered more or less helpless, in which condition he may betray himself and not protect his own interests. The efforts of the physician are not in the direction of healing and helping excepting when an innocent person is accused. For this and other reasons I believe that the physician should not act as the investigator. This can best be left to others who are charged with such a responsibility.

It is needless to add that as a practice the information obtained remains confidential, at least so far as the physician is concerned. I personally doubt very much whether anything obtained from a subject under the circumstances of such a procedure could ever be used against him at a trial. I believe, at least until the courts have passed upon this question and one is permitted to hold some views, that, even though the subject has consented to the procedure, this consent can hardly be regarded as covering all that he may subsequently utter while under a state of mental impairment. He is unable to give intelligent consent at the time the information is actually given. However, this and other matters are for the legal profession to weigh and decide.

CONCLUSIONS

The fact remains that, if properly used, carefully controlled and in the hands of an experienced person, some drugs, notably sodium amytal, will produce a prolonged state of mind during which reliable information can be obtained over which the subject has practically no control. I merely wish to emphasize the need of supervision by a medically trained person. The subject must be physically in proper condition, the pharmacology of the drug used must be understood and the mental state sought should be familiar to those undertaking this work.

Neurosyphilis; Incidence in Admissions to Wisconsin State Penal and Correctional Institutions During Year July 1, 1930 to June 30, 1931

By STUART A. McCORMICK, M. D.
Physician, Psychiatric Field Service
State Board of Control of Wisconsin
Madison

The total number of admissions into the state penal and correctional institutions for the year July 1, 1930 to June 30, 1931 was 1565. Each one of these admissions was given a thorough physical and mental examination by the Psychiatric Field Service of the State Board of Control of Wisconsin. In all cases showing history or presence of syphilis or presenting neurological signs, a spinal fluid examination was done. In addition, routine blood Wassermanns were taken as well as blood chemistry, urine examination, and a complete blood count. Any other laboratory examinations indicated were done.

A total of 173 spinal fluids were examined among the 1565 admissions. A diagnosis of neurosyphilis was made in 47 cases. In six cases a diagnosis of post-infectious residuals, chiefly attributed to encephalitis, was made. In the 47 cases in which a diagnosis of neurosyphilis was made, 13 or 27.6% had a negative blood Wassermann. In one case an anti-complementary blood Wassermann was rendered positive by the use of provocative intravenous injection of 0.4 gm. of neoarsphenamine.

These cases of neurosyphilis are unusual in that they present few signs or symptoms indicative of the pathology present. When one considers that the persons examined are those forced into an examination by reason of their incarceration, and in general have not sought medical aid, it makes one wonder how many in the general population are unknowingly suffering from neurosyphilis.

In the tables below are presented the signs and symptoms in this series of cases. It will be seen that the signs precede the symptoms and that the signs greatly outnumber the symptoms. It is, therefore, only in careful physical examinations followed by complete laboratory studies that many cases of neurosyphilis will be discovered. The cases in which mental symptoms were present are also listed, showing the necessity of considering syphilis as a basis for any mental disorder appearing in a patient.

TABLE I

Results in 173 Spinal Fluid Examinations on Admissions into State Correctional Institutions from July 1930 to July 1931.

	Men	Women	Boys	Girls	Total
Number taken	124	38	3	8	173
Positive for Neurosyphilis	33	11	0	3	47
Post-infectious encephalitis	5	0	1	0	6
Negative	86	27	2	5	120

TABLE II

Signs in 47 Cases of Neurosyphilis out of 173 Spinal Fluid Examinations in State Correctional Institutions July 1930 to July 1931.

Retarded or absent knee jerks	3
Retarded or absent ankle jerks	6
Sluggish pupils	10
Pupils unequal	6
Argyll Robertson pupils	2
Romberg Positive	5
Speech defect	2
One ear deafness	2
Knee jerks hyperactive	7
Hutchinson Teeth	2

Sources of Infection above 47 cases

History of Chancre	17
Congenital	2
Unknown	28

Symptoms in 47 Cases of Neurosyphilis

Shooting pains in legs or arms	3
Numbness in feet	2
Backache	1
Open sore	1
Headaches	3
Vision poor	2
Stomach trouble	1
Pains in abdomen	2
Tired feeling	1
Pains in legs	4
Mental symptoms	8

The table showing the source of syphilis is interesting in that so many claim no knowledge of luetic infection. It is, therefore, well to disregard the lack of history of luetic infection and proceed with a complete physical and laboratory investigation in order to avoid mistakes.

SUMMARY

A. Three percent (3%) or 47 cases of neurosyphilis were found in a total of 1565 admissions to the state penal and correctional institutions of Wisconsin for the year 1930–1931.

B. Thirteen of these cases (27.6%) had negative blood Wassermanns.

C. The source of infection was unknown in 28 cases or 59.57%.

D. The signs are relatively few, but outnumber the symptoms.

E. If these admissions constitute a cross section of the general population, then the incidence of neurosyphilis is high.

THE JOURNAL CLINIC

Submucous Lipoma of the Cecum; With Report of a Case

By C. F. DULL, M. D.
Richland Center

According to Comfort[1], who in 1931 published a comprehensive report on submucous lipomas of the gastro-intestinal tract, only eighteen cases of submucous lipoma of the cecum have appeared in the literature. Comfort's report includes five cases in which the lipoma caused no symptoms but was discovered at necropsy. The present case is thus the nineteenth case that is known to have existed and the fourteenth in which the lipoma was of clinical importance.

CASE HISTORY

In April, 1930, Mrs. R. F., aged 63, entered the Richland Hospital, complaining of severe intermittent pains over the right lower abdomen.

Past History.—The history revealed that she had had distress over the lower abdomen for the last five years. She belched frequently and obtained some relief from taking bicarbonate of soda. Chronic constipation was present, which necessitated the use of cathartics. In June, 1929, she had had an attack of intermittent pains in the lower abdomen, similar to the present attack except that the pains were then not severe. About one week before the present attack, she was treated by the author for influenza and at this time abdominal examination was negative.

Present Condition.—On admission to the hospital, the general examination showed a normally developed and well nourished woman, appearing acutely ill. The temperature was 100.6 F., the pulse 108, the respirations 28. Examination of the abdomen showed marked tenderness and rigidity over McBurney's point, with a palpable mass the size of an egg. Rectal examination revealed a hard mass in the region of the appendix. Repeated examinations of the urine were normal, both grossly and microscopically. The white blood cell count was 15,000.

Operation.—An exploratory abdominal operation was performed the same day. The vermiform appendix, which was acutely congested and thickened, was removed in the usual manner. Further examination revealed a mass about the size of an egg within the cecum and attached firmly to the right lower wall. The mass appeared to be obstructing the lumen of the small bowel as it entered the cecum. When the cecum was opened, it was seen that a tumor had dropped over on to the outlet of the small bowel. By enterectomy the tumor mass was removed with a portion of the cecal wall. The cecum was sutured with two rows of intestinal sutures, two small cigarette drains were inserted and the abdomen was closed. The dimensions of the tumor were: 6 cm. by 5 cm. by 4 cm. The patient made an uneventful recovery and left the hospital on the nineteenth day after operation.

Fig. 1.

Pathologic examination of the tumor showed a lipoma of the submucosa with an ulcerative colitis over it and considerable subacute inflammatory reaction in the intestinal wall and in the tumor.

In 1932 the patient does not complain of abdominal distress and is not constipated. The postoperative roentgenologic examination shows a filling defect in the cecum but no obstruction.

This case presents a typical course for a gradually developing obstruction of the intestine with exacerbations. The discomfort in the lower abdomen, not sufficient at any time to rouse the patient to a sense of something seriously wrong, but continuing unrelieved for a period of years, the constipation which likewise becomes chronic and is so

Fig. 2. X-ray, 1932, shows filling defect in cecum, but no obstruction to the ileum where it enters the cecum.

stubborn as to require the use of cathartics, are the phenomena that may be expected in the case of benign tumor of the intestine. Then comes the first exacerbation, an attack of intermittent pain sufficiently definite in character to be differentiated from the vague distress to which the patient is habituated, but not yet severe enough to be accepted as a warning. The patient recovers from this attack and goes on as before for another ten months, when she is stricken with influenza. This illness gives occasion for physical examination and it is now particularly noted that the abdomen presents nothing unusual, no points of tenderness or swelling. Just a week later comes the second exacerbation, with symptoms suggesting appendicitis and a mass that is palpable externally as well as from the rectum. Just what influence, if any, the influenza had in precipitating the acute attack at this time appears uncertain; in no published case have

Fig. 3. Shows tumor and inside of bowel with portion of tumor cut off.

I seen mention of an acute infectious disease preceding the manifestations of obstruction from intestinal lipoma.

Lipoma of the intestine is symptomless until it has attained sufficient size to cause trouble either by encroaching on the lumen of the bowel or by stimulating peristalsis in such a manner as to give rise to intussusception. This complication has occurred in about half the reported cases of submucous lipoma of the large intestine and is still more frequent in the small intestine. Obstruction may be acute, subacute or chronic; it may be partial or complete, progressive or intermittent; the chronic and subacute varieties may be subject to exacerbations. When the growth occurs in the cecum, the diagnosis is frequently made more difficult by the fact that the symptoms are likely to resemble those of acute appendicitis.

ILLUSTRATIVE CASES

A case reported by Nash[2] bears a close likeness to mine in several respects, including the similarity of the clinical picture to appendicitis. The patient was a woman, aged 61, who six months previously had had an attack of diarrhea, which was followed by attacks of abdominal pain and severe constipation. One week before she entered hospital she had severe colicky pain and vomiting. She was admitted as a case of appendicitis. On admission there was definite tenderness and rigidity in the right lower quadrant of the abdomen. The temperature was 99 F., the pulse rate 90. The appendix was found thickened but not inflamed. The cecum felt as if it

contained a mass of worms. It was opened and a submucous lipoma was found projecting from the posterior wall. The overlying mucous membrane was incised and the mass shelled out. The tumor measured 10 cm. by 6.25 cm.

Derocque and Derocque's[3] case is worthy of mention for the chronicity of the symptoms. For ten years a woman 30 years of age had suffered intermittent abdominal pain, not well localized, but worse on the left side, and severe enough to keep her in bed from time to time. A severe exacerbation of the pain, situated this time in the right iliac fossa and accompanied by diarrhea, was treated conservatively as appendicitis. The pains became more severe and at the end of six weeks operation was performed. The appendix was normal except for the base, which was congested. The cecum appeared to be filled with a soft mass suggesting fecal material, which, however, could not be mobilized. The cecum was opened and a submucous lipoma, the size of a small orange, was found broadly implanted on the posterior surface near the orifice of the appendix.

In other cases there is no lengthy history of abdominal symptoms. The obstruction is brought about acutely by intussusception. The tumor, acting as a foreign-body irritant, has excited expulsive efforts on the part of the intestinal wall, which have driven forward the tumor-bearing portion in the manner of invagination. Thus in Collins'[4] case the patient had attacks of pain in the right lower quadrant several times daily for two or three days, accompanied by nausea and vomiting. This attack was followed by a blood-stained mucoid discharge four or five times a day. Examination two weeks later showed a fixed oblong mass lying obliquely in the left lower part of the abdomen. Laparotomy disclosed intussusception and a round, pedunculated lipoma, 5 cm. in diameter, attached to the inner wall of the cecum. In a case reported by Cicala[5] the cecum was found in the transverse colon. It contained a submucous lipoma, about 8 cm. in diameter.

Cicala's case also illustrates a difficulty that may arise in distinguishing this condition from peptic ulcer—a relation between the attacks of pain and the time of taking food. This patient had had an intense burning sensation in the hypochondrium after meals. In a case described by Longo[6] colicky and intermittent pain in the right abdomen came on slowly after meals. Vomiting and marked constipation appeared later. This connection between attacks of pain and the taking of food has been observed in cases of submucous lipoma of other segments of the intestine as well as in the cecum.

It is rarely that a more exact diagnosis than obstruction will be made before operation. The length of time that the symptoms have been present and in some cases roentgenologic examination can aid in making a decision between benign and malignant tumor, but the history may be deceptive on this point, since obstruction may occur acutely, especially through intussusception, without a previous train of symptoms, and also because rapid loss of weight, which might suggest malignancy, is not unusual with intestinal lipoma. When the cecum has been exposed, it is sometimes possible, if the tumor is sessile and large, to detect the characteristic yellow color of the fatty tumor through the muscle.

Lipomas in the intestine may develop beneath the serosa as well as beneath the mucosa. Both kinds have been found in the same patient. The submucous variety is the more common and is the more likely to cause trouble, because it cannot attain any considerable size without encroaching seriously on the lumen of the bowel. In the five symptomless cases of submucous cecal lipoma in Comfort's[1] series, the largest tumor measured 4.5 cm. by 1.5 cm. by 2 cm., and two were measured in millimeters.

The mucous membrane over the lipoma may be normal, but it is sometimes thinned or atrophic, sometimes ulcerated, as in my case, and sometimes necrotic. Ulceration and necrosis, as well as edema, congestion, hemorrhage into the substance of the tumor, and infiltration with leukocytes are results of interference with the circulation. These changes may lead to a considerable swelling of the tumor. This fact, Comfort[1] remarks, would explain certain cases in which obstructive symptoms were present and yet the tumor, when exposed at operation, appeared too small to have caused obstruction commensurate with the symptoms. In a case that he reports a diminution of 1.5 cm. in the diameter of the tumor was noted to have taken place between the stages of a two-stage operation.

The presence of collections of fat cells in the submucosa of the intestine is not unusual, and whether, as Comfort[1] observes, lipomas are conceived of as metaplastic, heterotopic, inflammatory or neurosecretory in origin, the growth of such collections of cells into a lipoma can be easily visualized. In fact, the process can be traced in different specimens through all the stages from a small collection of fat cells in the submucosa to a large lipomatous tumor.

Benign tumors form but a small percentage of all neoplasms of the intestinal tract, and of this small percentage the greater number are adenomatous polyps. Lipomas and myomas come next in frequency. Lipomas that produce symptoms appear to be twice as frequent in the large as in the small intestine and the most common sites are the cecum and ascending colon.

Unlike other benign tumors of the intestine, lipoma tends to occur singly, but a few cases of multiple submucous lipomas are on record. In one a lipoma of the ascending colon was present with a lipoma of the cecum (Stetten's [7] collection), and in one of Comfort's[1] silent cases three submucous lipomas were found, one in the cecum, one on the ileocecal valve and one in the ascending colon.

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Single Lesion of Osteitis Deformans*

(Paget's Disease)

By LAWRENCE V. LITTIG, M. D.
Madison

The following case is reported because it is a rare form of an infrequent disease, most frequent in males. Paget's disease of bone occurs usually after the age of forty-five. The lesions are generally multiple, affecting most frequently the tibiae, skull, pelvis, spine and femurs. The bones of the calvarium are greatly thickened with an uneven density giving a fuzzy appearance. The long bones, spine and pelvis, when involved, show thickening and areas of increased and decreased density. Throughout the involved area coarse, bony trabeculations are evident. The tibiae become bowed anteriorly. Cyst formation occurs most frequently in the tibiae.

Paget's disease of bone is considered a low grade chronic osteitis. Sarcomatous changes occur in five to seven percent of cases. When the disease occurs as a single lesion the tibia is most frequently involved as in our case.

CASE REPORT

Mrs. O., housewife age 52, was referred by Dr. P. R. Fox, January 26, 1932, because of pain and swelling in the left calf. She first noticed marked discomfort in the calf of the left leg five weeks previously following a slight bump on the shin. For the past five years she has had at times some discomfort in the left leg described as a very mild ache in the calf and over the shin. She noticed no swelling until five weeks ago when she bumped her left shin on a step ladder. Since then the leg has swollen, most noticeably in the evening, after being on her feet all day. Otherwise she feels perfectly well and has had no serious illnesses. The physical examination was negative except for the left leg which was enlarged, fusiform in shape and bowed anteriorly. On palpation the swelling was hard and confined to the tibia, except for some varicose veins and oedema of the ankle. The left calf was 4 cm. greater in diameter than the right.

The laboratory examinations showed 4,720,000 R. B. C., 85% Hb., 6,000 W. B. C., with 64% polymorphonuclear leukocytes. The urine was negative as was the Wassermann.

X-ray examination of all of the bones of the body was negative except for the left tibia (fig. 1). The proximal three-fourths of the left tibia is involved with a bone ex-

* Department of Radiology, Madison General Hospital.

Fig. 1. Paget's Osteitis Deformans. (Single Lesion). Note thickening and anterior bowing of the tibia. Also coarse trabeculae and cystic areas.

panding lesion of long standing. The cortex is thickened and the tibia is bowed anteriorly. Throughout the involved bone are areas of increased and decreased density. New bone has been laid down in coarse trabeculations and there are numerous small cyst-like formations.

The age of the patient and the characteristic bone picture make this a typical case of a single lesion of Paget's osteitis deformans. The recent increase in symptoms was due to thrombosis of varicose veins.

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Cancer of the Nose; Report of Case Treated with Radium

By R. L. ZAEGEL, M. D.
Sheboygan Clinic
Sheboygan

The unusual case of Mr. W. D., who came to The Sheboygan Clinic for treatment on June 6, 1931, with the following history, is believed to be worth reporting.

Two years before he had been struck on the nose by another man and the resulting laceration did not heal promptly. Gradually the unhealed area became ulcerated, grew larger, and became hard. He went to one doctor after another and received various

Fig. 1.

Fig. 2.

treatments, but was informed during the last few months that there was no hope for him and treatment would not help him.

When first seen the condition was thought to be hopeless, but as surprising results in uterine and breast cancer cases have been obtained when they were apparently beyond treatment, it was decided to treat with radium and if not successful it would at least make him feel hopeful for the time being.

On examination a large cancer of the nose and a small one of the lower lip were found, as can be seen by the picture. The entire face had an erysipelas-like appearance, and much pus was being exuded from the nasal growth. A total of 3970 milligram hours of radium was applied within the nostril and upon the outside of the two growths during a period of five days.

The second picture was taken about three months later. There is a small hole in the left nasal ala, and the mustache had to be removed because the radium caused the hair to fall out.

Double Vagina and Double Cervices; Report of Case*

By J. F. HENKEN, M. D.
Racine

A double vagina is an uncommon anomaly and when present is usually associated with some form of double uterus. But a more rare condition is a double vagina with two cervices entering one uterus as in the present case. This anomaly arises from an arrest in the fusion of the two separate tubes, "the Mullerian ducts," which normally unite in the embryo to form the uterus.

The vaginal septum may be easily overlooked, for it usually has considerable mobility and may be pushed aside at examination. It is also frequently the case that one vagina is larger than the other. One side may be atresic and should this communicate with one side of a double uterus, symptoms of gynatresia may follow.

A girl, aged eighteen years, was referred to me for cystoscopic examination, presenting symptoms of malaise, weakness, painful micturation, frequency and non-specific leukorrhea. Examination revealed a greenish mucoid plug covering the entire vulva within the labia minora. A secondary cystitis was present due to bladder irrigations and infection from the leukorrhea.

(Continued on page 278)

* Read before Racine County Medical Society, February 17, 1932.

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EDITORIALS

THE COMPENSATED VALVULAR HEART LESION

THERE was a time, not so many years ago, that heart murmurs were looked upon as very serious defects. The writer well remembers how many weary hours were spent in accurately describing the murmurs because it was thought that from the murmurs heard over an abnormal heart one could form an estimate of the competency of the heart and give a prognosis of the condition.

Since Sir James Mackenzie demonstrated so conclusively that the heart muscle was the all-important factor and murmurs were but indications of mechanical embarrassment of greater or less extent, the inevitable tendency grew to discount all murmurs. Either extreme view does not represent the true state of affairs. Modern studies of the heart have shown that all factors, murmurs, size of heart, response to exercise, frequency of infections, etc., must be taken into consideration in order to give an intelligent prognosis and to guide the individual with the abnormal heart.

In spite of all the literature which has accumulated in regard to heart conditions; in spite of the overwhelming evidence now at hand showing the much greater importance of heart muscle competency than of valvular competency, there are still numerous physicians who treat every compensated valvular heart lesion in a child or young adult as if the individual were on the verge of heart failure. This is certainly wrong. It is a relic of past teaching now known to be false. How long will it take for physicians to appreciate that a heart with a valvular lesion is not necessarily a weak heart?

If the heart is judged to be weak, how can it be strengthened? Is it by advising the patient to live a quiet life, by interdicting all forms of bodily exercise? Is heart muscle so different from skeletal muscle that it can grow strong by rest? There is only one way to strengthen heart muscle and that is by making it work. To make it work the whole body must have exercise. Persons with well compensated heart lesions who do not have any more dyspnea on exertion than the person with a normal heart, should not only be allowed to exercise but they should be forced to exercise. *As long as they do not suffer with dyspnea which does not quickly pass away on rest as it does with a normal heart,* they should be encouraged to take gymnasium work, to skate, to play all sorts of games. Excessive and violent competitive athletics should be prohibited, for the damaged heart can be strained under such conditions.

Far more important in its effects upon the valvular heart lesion is any intercurrent infection particularly influenza. Following

upon such an infection, the patient should take a much longer time to convalesce than is usually allowed. Influenza evidently attacks the heart muscle rendering it more easily susceptible to strain, so that time and rest must be given in order that the muscle may return to its condition previous to the infection.

Examples could be cited of many young men and women with mitral stenosis or aortic insufficiency who have played all sorts of violent games with no harm to their hearts. Such patients should be examined from time to time and the exercise tolerance inquired about and tested.

We wish to take the side of these youngsters who feel so out of everything, and urge upon physicians not to forbid normal activities to the adolescents with compensated heart lesions. L. M. W.

WHERE IS THE OTHER CASE?

THE theme "Where is the Other Case?" of the National and State Tuberculosis Associations' 1932 Early Diagnosis Campaign is one to which we, as medical men, interested in the welfare of our patients and their families, may well give serious thought and consideration. "Where is the Other Case?" is of course based on the scientific fact that every case of tuberculosis comes from another case of tuberculosis.

Years ago tuberculosis was considered a family disease because it was thought to be inherited; after the accumulation of sufficient scientific data, the inherited idea was abandoned, but because the disease still appeared in many members of the same families, the compromise term "inherited tendency" was substituted. Today this term has likewise been thrown into the discard because we know better. 'Tis true, tuberculosis is today still a family disease, but only because it is a communicable disease.

Transmitted through intimate exposure to an open case, it is but logical that many of the cases occur through close family association. Nowhere is the opportunity of prolonged intimate exposure more common than in the family circle.

Accordingly whenever a diagnosis of tuberculosis is made, the members of the patient's family should be the first to be examined. The grandfather who is quite well for his age but who has had a "chronic bronchitis" for years; a sister or aunt living in the house who had a "nervous breakdown" several years ago; a servant whose history is not well known to the family; or any other member of the household not infrequently will be found to be the probable source of infection. If possible, all members should be given a careful physical and x-ray examination.

If the family is shown to be clear, how about some close or intimate friend? A room-mate at school, a co-worker at the same desk in the office, may be "that other case".

The 1932 Early Diagnosis Campaign is intended to call attention to the fact that "tuberculosis causes tuberculosis", and it is sincerely hoped that physicians throughout the state will carry on and find "That Other Case." O. L.

OUR DUTY

"I have uniformly advised against the adoption of any advertising plan by medical societies, whether it be the county society or the state organization. In my opinion, the lay press, which claims to be an educational institution, has a peculiar responsibility for giving to the public helpful information. However, the medical profession should not be taxed with the cost of such publication.

"I do consider it the duty of organized medicine to give to the press, for the benefit of the public, such information as may be helpful and which can not be provided from any other source. A number of our constituent state medical associations have active committees under whose auspices such material is prepared and carried in most of the newspapers of the states concerned. This is especially true of the Indiana State Medical Association and the State Medical Society of Wisconsin." Dr. Olin West, Secretary and General Manager, American Medical Association. Reprinted from The West Virginia Medical Journal, November, 1931.

THE PRESIDENT'S PAGE

POOR, POOR RELIEF

IN EVERY period of economic depression, every economic crisis, large groups of our people, who in ordinary times are independent and fully able to provide for themselves, become temporarily dependent and the objects for relief. This is not through any fault of their own but through the failure of the system under which we live to have taken any forethought or made any provisions for the evil days in which we find ourselves. In such crises there is always an aggravation of the inability of many of our citizens to provide for themselves the necessities of life—food, shelter, clothing, and medical service. I add the latter for we must agree that this item is a real necessity from the point of view of the individual and of the social body. It is only as the worker can be kept physically fit that he can ever hope to take his place as a useful citizen in the ranks of the producers of the community.

Medical relief of these unfortunate people should be sharply differentiated from the charity which is extended to another class. The social body, through whose dysfunction the former have become dependent, is responsible for their plight and it should assume its responsibility. Without doubt, future generations looking back to this period will be astounded at the wholly inadequate method, the inefficient system by which we have attempted to meet this obligation, and will make us ashamed and chagrined that the methods are so indefensible from the social point of view.

Relief of these unfortunates is a mandatory duty of the proper officials of the State. In some counties of Wisconsin relief is handled by a county system. In others we find county care under a county system for the non-residents, but the town officer must authorize the care of the resident dependent. Non-official organizations whose proper functions are charity have assumed duties in the field of poor relief. Consequently, government officials have kept the cost off the tax rolls and now when charity organizations are unable to carry the load, officials are reluctant to assume it. We have in consequence a divided responsibility which often means no responsibility, and very poor, poor relief.

If we will exercise effective and fundamental thinking relative to this problem, this condition need not continue. If we do not give the matter the serious attention it deserves, we will have failed in our full duty as physicians, for we know that something needs to be done. Our State Society has prepared and distributed a digest of the laws and the rulings made thereon, relating to poor relief. This digest will inform our members how to procure proper authorization for medical relief and it will be especially valuable if it demonstrates the need for a change in the present complicated system. Data now compiled, and other statistics being collected by our Society, fully demonstrate that the physician can not assume medical care of the poor as his obligation. Such patients constitute too large a proportion of his clientele, and if the public expects this, we shall find incomes for physicians so reduced that many communities will lose the doctor and be left without medical service. Medical relief of those unable to pay is a community responsibility and must be assumed by the social body. Our large cities too long have assumed the responsibility for food, shelter, clothing, schooling, in fact all the necessities of life except medical care. So that now the sick who attempt to maintain their independent state must, in part at least, meet costs that should be borne by the community.

It must be apparent that a change is necessary and that our Society must awaken to this need and provide the leadership which shall right this evil. It is hoped that at the September meeting some definite recommendations may be presented which will be worthy of adoption by the Society, and that there shall be provided a method that shall lead to a new system of efficient poor relief in place of the poor, poor relief now obtaining in our commonwealth.

THE STATE MEDICAL SOCIETY OF WISCONSIN

ORGANIZED 1841

OTHO FIEDLER, Sheboygan, President
REGINALD JACKSON, Madison, Pres.-Elect
STANLEY J. SEEGER, Milwaukee, Speaker
M. D. BIRD, Marinette, Vice-Speaker
ROCK SLEYSTER, Wauwatosa, Treasurer
Mr. J. G. CROWNHART, Secretary, Madison

Councilors

TERM EXPIRES 1933
1st Dist., A. W. Rogers ..Oconomowoc
2nd Dist., Frank W. Pope .....Racine

TERM EXPIRES 1934
3rd Dist., C. A. Harper .....Madison
4th Dist., W. Cunningham .Platteville

TERM EXPIRES 1934
5th Dist., A. H. Heidner ...West Bend
6th Dist., S. E. Gavin ....Fond du Lac

TERM EXPIRES 1932
7th Dist., S. D. Beebe .....Sparta
8th Dist., T. J. Redelings ...Marinette

TERM EXPIRES 1932
9th Dist., Joseph F. Smith ..Wausau
10th Dist., H. M. Stang ....Eau Claire

TERM EXPIRES 1933
11th Dist., F. G. Johnson ..Iron River
12th Dist., R. W. Blumenthal, Milwaukee

Delegates to American Medical Association

J. GURNEY TAYLOR, Milwaukee
W. E. BANNEN, La Crosse
JOSEPH F. SMITH, Wausau

Alternates

F. G. CONNELL, Oshkosh
T. W. NUZUM, Janesville
M. D. BIRD, Marinette

Committee on Public Policy

OTHO FIEDLER, Sheboygan, Chairman
S. M. B. SMITH, Wausau
REGINALD JACKSON, Madison

Committee on Medical Defense

A. J. PATEK, Milwaukee, Chairman
W. C. BECKER, Watertown
A. G. SULLIVAN, Madison

Committee on Health and Public Instruction

W. D. STOVALL, Madison
C. M. GLEASON, Manitowoc
H. M. STANG, Eau Claire

The Wisconsin Medical Journal, Official Publication
Advertising Representative: Cooperative Medical Advertising Bureau, 535 North Dearborn St., Chicago, Ill.

LIST OF EXECUTIVE OFFICERS OF COUNTY MEDICAL SOCIETIES

County	President	Secretary
Ashland-Bayfield-Iron	John M. Dodd, Jr., Ashland	J. W. Prentice, Ashland.
Barron-Washburn-Sawyer-Burnett	C. F. Cronk, Cameron	A. D. Galloway, Barron.
Brown-Kewaunee	E. S. Knox, Green Bay	W. E. Mueller, Green Bay.
Calumet	A. C. Engel, New Holstein	J. W. Goggins, Chilton.
Chippewa	F. T. McHugh, Chippewa Falls	J. A. Kelly, Chippewa Falls.
Clark	R. R. Rath, Granton	A. L. Schemmer, Colby.
Columbia	K. A. Snyder, Portage	H. Y. Fredrick, Westfield.
Crawford	A. E. Dillman, Steuben	C. A. Armstrong, Prairie du Chien.
Dane	F. F. Bowman, Madison	F. L. Weston, Madison.
Dodge	E. P. Webb, Beaver Dam	A. W. Hammond, Beaver Dam.
Door	John Hirschboeck, Forestville	
Douglas	H. A. Sincock, Superior	C. H. Christiansen, Superior.
Eau Claire and Associated Counties	E. E. Tupper, Eau Claire	P. G. Spelbring, Eau Claire.
Fond du Lac	J. C. Yockey, Fond du Lac	H. R. Sharpe, Fond du Lac.
Grant	E. A. A. Dunn, Platteville	M. B. Glasier, Bloomington.
Green	W. B. Gnagi, Sr., Monroe	J. F. Mauermann, Monroe.
Green Lake-Waushara-Adams	G. E. Baldwin, Green Lake	A. J. Wiesender, Berlin.
Iowa	S. R. Ridley, Mineral Point	H. M. Walker, Dodgeville.
Jefferson	A. C. Nickels, Watertown	A. A. Busse, Jefferson.
Juneau	C. A. Vogel, Elroy	A. T. Gregory, Mauston.
Kenosha	A. Schlapik, Kenosha	W. H. Lipman, Kenosha.
La Crosse	R. L. Eagan, La Crosse	G. D. Reay, La Crosse.
Lafayette	R. B. Quinn, Darlington	W. B. Williams, Argyle.
Langlade	C. E. Zellmer, Antigo	J. C. Wright, Antigo.
Lincoln	F. L. Kelley, Merrill	W. H. Bayer, Merrill.
Manitowoc	C. H. Barnstein, Newton	E. C. Cary, Reedsville.
Marathon	Joseph F. Smith, Wausau	Verne E. Eastman, Wausau.
Marinette-Florence	T. J. Redelings, Marinette	C. H. Boren, Marinette.
Milwaukee	P. M. Currer, Milwaukee	Theo. Wiprud, Ex. Sec'y, Milw.
Monroe	A. E. Winter, Tomah	H. H. Williams, Sparta.
Oconto	R. J. Goggins, Oconto Falls	G. W. Krahn, Oconto Falls.
Oneida-Forest-Vilas	C. D. Packard, Rhinelander	I. E. Schiek, Rhinelander.
Outagamie	E. F. Mielke, Appleton	R. V. Landis, Appleton.
Pierce-St. Croix	H. P. Conway, Spring Valley	A. E. McMahon, Glenwood City.
Polk	L. O. Simenstad, Osceola	Geo. B. Larson, Frederic.
Portage	F. A. Marrs, Stevens Point	H. P. Benn, Stevens Point.
Price-Taylor	F. W. Mitchell, Medford	G. L. Baker, Rib Lake.
Racine	C. O. Schaefer, Racine	Susan Jones, Racine.
Richland	W. C. Edwards, Richland Center	G. Benson, Richland Center.
Rock	G. S. Metcalf, Janesville	E. C. Hartman, Janesville.
Sauk	Roger Cahoon, Baraboo	A. C. Edwards, Baraboo.
Shawano	C. E. Stubenvoll, Shawano	L. W. Peterson, Shawano.
Sheboygan	H. F. Deicher, Plymouth	A. C. Radloff, Plymouth.
Trempealeu-Jackson-Buffalo	R. L. Alvarez, Galesville	R. L. MacCornack, Whitehall.
Vernon	W. M. Trowbridge, Viroqua	Wm. H. Remer, Chaseburg.
Walworth	S. G. Meany, East Troy	V. S. Downs, Lake Geneva.
Washington-Ozaukee	N. E. Hausmann, Kewaskum	P. M. Kauth, West Bend.
Waukesha	J. C. Hassall, Oconomowoc	J. F. Wilkinson, Oconomowoc.
Waupaca	R. K. Irvine, Manawa	F. J. Pfeifer, New London.
Winnebago	G. E. Forkin, Menasha	M. C. Haines, Oshkosh.
Wood	F. X. Pomainville, Wisconsin Rapids	W. G. Sexton, Marshfield.

SOCIETY PROCEEDINGS

EAU CLAIRE

A meeting of the Eau Claire and Associated Counties Medical Society was held on February 29th at Hotel Eau Claire with a dinner at six o'clock. The following scientific program was given:

"Poliomyelitis" by Dr. George N. Ruhberg, St. Paul. Discussion of this paper was led by Dr. E. L. Mason of Eau Claire.

"The Healing of Fractures; Its Relation to Malunion, Delayed and Non-Union" by Dr. Edward T. Evans, Minneapolis. Dr. Iver Stoland of Eau Claire led the discussion.

FOND DU LAC

Dr. Carl B. Davis of Chicago was speaker at a dinner meeting of the Fond du Lac County Medical Society held on March 9th at the Hotel Retlaw.

GREEN

A business meeting of the Green County Medical Society was held in the offices of Drs. W. B. Gnagi and W. B. Gnagi, Jr., Monroe, on February 23rd.

GREEN LAKE–WAUSHARA–ADAMS

The February meeting of the Green Lake–Waushara–Adams County Medical Society was held at Princeton with a dinner served at seven o'clock at the American House. Following this a business meeting was held at which Dr. V. A. Gudex of the State Board of Health spoke to the members on "Toxin-Antitoxin."

MANITOWOC

Dr. A. A. Pleyte, staff member of the Wisconsin Anti-Tuberculosis Association was the speaker at a meeting of the Manitowoc County Medical Society held on March 17th at Hotel Manitowoc.

MILWAUKEE

At the monthly meeting of the Medical Society of Milwaukee County, held at the Pfister Hotel on March 11th, the following program was presented:

"The Treatment of Burns, with Report of Research" by Stanley J. Seeger, M. D.

"Application of Organo Therapy to Gynecology and Obstetrics" by H. W. Shutter, M. D.

"How Can We Control the Destiny of the Medical Profession?" by John J. McGovern, M. D.

Dr. Seeger's paper was discussed by Dr. E. H. Mensing, Dr. Shutter's, by Dr. J. H. Sure, and Drs. Gilbert E. Seaman, Henry J. Gramling, Fred W. Riehl, and Mr. J. G. Crownhart discussed Dr. McGovern's paper.

It was a very large and enthusiastic meeting, with about 350 members present.

OUTAGAMIE

Dr. C. G. Sutherland, roentgenologist at Mayo Clinic, was the speaker before a meeting of Outagamie County Medical Society held at Hotel Northern, March 15th. Dr. Sutherland spoke on the use of the x-ray in diagnosis and illustrated his talk with lantern slides.

POLK

The annual joint dinner meeting of the Polk County Medical Society and the Polk County Editorial Association was held at Luck on Thursday, March 17th.

Mr. Roy Dunlap, managing editor of the St. Paul Pioneer Press presented the "Minnesota Plan" of Society newspaper advertising as prepared by the joint committee of the Minnesota State Medical Society and the Minnesota Editorial Association.

Mrs. Wm. F. Sailor of St. Paul gave an interesting and humorous resume of newspaper experiences in connection with the medical profession. G. B. L.

RACINE

The regular meeting of the Racine County Medical Society was held at the Elks Club, Racine, on Thursday evening, March 17th, at eight o'clock.

Dr. Stanley J. Seeger of Milwaukee presented a paper with lantern slides on "Carcinoma of the Rectum."

Dr. Alfred A. Strauss, chief of gastroenterological group of the Michael Reese Hospital, Chicago, presented a discourse on "Peptic Ulcers."

General discussion followed by members of the Society.

Dr. Ira F. Thompson, health commissioner of Racine, was duly elected a member of the Society.

S. J.

ROCK

Members of the Rock County Medical Society met at Hotel Hilton, Beloit on February 23rd. Dinner was served at six-thirty o'clock after which two addresses were given by members of the Mayo Clinic.

Dr. Harry J. Fortin spoke on "Arthritis and Its Treatment" while Dr. Albert M. Snell gave a talk on "Observations in the Diagnosis and Treatment of Peptic Ulcers". Both talks were illustrated with lantern slides.

WINNEBAGO

Members of the Winnebago County Medical Society met at the home of Dr. C. J. Combs, 502 Washington Blvd., Oshkosh, to hear Dr. Ira R. Sisk of the Medical School of the University of Wisconsin, who spoke on "Traumatic and Surgical Injuries of the Urinary Tract."

MILWAUKEE ACADEMY OF MEDICINE

At the regular meeting of the Milwaukee Academy of Medicine, held on March 15th, the following program was presented:

"Cutis Verticis Gyrata: An Occasional Early Cutaneous Sign of Pituitary Disease" with presentation of a case by Dr. L. M. Wieder, Milwaukee.

"Clinical Haematology with Special Reference to the Leucopenic State" by Dr. Charles A. Doan, professor and head of the department of medical and surgical research, Ohio State University College of Medicine, Columbus, Ohio.

MILWAUKEE HOSPITAL INTERNS

The Milwaukee Hospital Interns' Association held a meeting open to members only at the home of Dr. Leon Guerin on March 16th. Dr. George Kelly spoke on "Some Phases of Pediatrics"; Dr. Guerin on "Tonsils and Adenoids in Children," and Dr. S. M. Turkeltaub on "Renal Tuberculosis in Children."

MILWAUKEE NEURO-PSYCHIATRIC

At a meeting of the Milwaukee Neuro-Psychiatric Society held at the University Club on March 24th, Dr. Peter Bassoe of Chicago spoke on "Some Clinical Observations on Vasomotor Disturbances in the Head."

MILWAUKEE OTO-OPHTHALMIC

The March meeting of the Milwaukee Oto-Ophthalmic Society was held on the 29th at the Wisconsin Club. The scientific program consisted of the following:

"The Common Form of Ethmoiditis," by Dr. B. S. Hill, Kenosha.

"Recurrent Retinal Hemorrhages," by Dr. Mark Bach, Milwaukee.

UNIVERSITY OF WISCONSIN

Dr. Jay Arthur Myers, associate professor of medicine and preventive medicine and public health, University of Minnesota, gave an address on "Recent Studies in Tuberculosis," on Thursday evening, March 31st, in the auditorium of the Service Memorial Institutes building, Madison. This was the fifth annual address under the William Snow Miller Lectureship, established in 1928 by the Phi Beta Pi Medical Fraternity.

THE WOMAN'S AUXILIARY

Mrs. Orvil O'Neal, Ripon, Editor

The Columbia County Medical Society Auxiliary met with the Medical Society Feb. 11 at Hotel Raulf for a six-thirty dinner. The ladies attended the theater after dinner.

* * *

Rock County Auxiliary held its annual election of officers at the Monterey Hotel, Janesville, January 29th. Eighteen members were present.

The following officers were unanimously elected:

Mrs. T. O. Nuzum, President, Janesville.

Mrs. H. E. Kasten, President-elect, Beloit.

Mrs. T. J. Snodgrass, Sec'y-Treas., Janesville.

Mrs. Nuzum entertained six members at an afternoon tea, at her home and appointed her committees and mapped out the program for the year.

The February meeting was held at the Hotel Hilton, Beloit, on Feb. 23, with twenty-five members present. Mrs. H. E. Kasten presented five reels of motion pictures taken while on a trip to Europe last year and gave an interesting talk of all the important places which she and Dr. Kasten visited.

The following are the programs for the balance of the year:

March 29 at Janesville with Mrs. E. C. Hartman in charge of a talk on State Medicine.

April 26 at Beloit with a program on vivisection under the direction of Mrs. C. F. N. Schram.

May 24 at Janesville with Mrs. V. Koch presenting a program on Hygeia.

June 28 at Beloit with Mrs. William Hecker in charge of a program on public school health units.

October 25 at Janesville with county health unit program under the direction of Mrs. M. Baumgartner.

Nov. 22 at Janesville with social committee in charge of a Thanksgiving party.

January 25, 1933, at Beloit with election and reception of new officers.

The Rock County ladies are to be commended on their instructive and constructive programs.

* * *

The Auxiliary and the Doctors of the Green Lake–Waushara–Adams County Society met at Princeton on Feb. 18th for a social evening. After a seven o'clock dinner at the American Hotel, Dr. Gudex, member of the State Board of Health gave a short talk on Toxin-Antitoxin. The members were then all entertained at the home of Dr. and Mrs. Mueller. Honors for high score in bridge were awarded to Mrs. B. B. Scott of Milwaukee, a house guest of Dr. and Mrs. Scott of Berlin and to Dr. Eisele of Ripon.

Mrs. A. E. Beck of Wautoma was also a guest of the combined organizations. At the close of the evening Dr. and Mrs. Mueller again served pleasing light refreshments.

* * *

At the monthly meeting of the Woman's Auxiliary to the Medical Society of Milwaukee County held at the Wisconsin Hotel on March 11th, Dr. Arthur J. Cramp, director of the bureau of investigation, American Medical Association, spoke on "Patent Medicine And The Public."

WOMAN'S AUXILIARY TO THE AMERICAN MEDICAL ASSOCIATION

Tenth Annual Meeting
New Orleans
May 9–13, 1932

Headquarters: JERUSALEM TEMPLE, 1137 ST. CHARLES AVENUE

PRELIMINARY PROGRAM

Monday, May 9, 1932

6:00 P. M. National Board Dinner and Pre-Convention Meeting (for Board Members, only) __Orleans Club, 5005 St. Charles Avenue
Tickets $1.50

Tuesday May 10, 1932

9:00 A. M. General Meeting___Jerusalem Temple
Mrs. Arthur B. McGlothlan, *presiding*
12:30 P. M. Buffet Luncheon____Jerusalem Temple
Tickets $1.00
2:00 P. M. Walk Through Vieux Carre, with Guides — Starting From the Patio Royale
4:00 P. M. Tea _____Patio Royale
8:00 P. M. General Meeting of the American Medical Association _____Auditorium

Wednesday, May 11, 1932

9:00 A. M. General Meeting___Jerusalem Temple
Mrs. Arthur B. McGlothlan, *presiding*
12:30 P. M. *Auxiliary Luncheon__Southern Yacht Club
(12 Minutes from Canal Street or Jerusalem Temple Luncheon tickets, $1.50; Transportation, 25 cents)
2:30 P. M. Post-Convention Board Meeting_____ _____Southern Yacht Club
2:30 P. M. *Through Garden Gates; Glimpses of New Orleans
4:00 P. M. Teas in Private Residences

New Orleans Country Club

8:30 P. M. Divertissements in the Garden
10:00 P. M. Buffet Supper
Negro Spirituals_____Courtesy of the Woman's Auxiliary to the Louisiana State Medical Society

Thursday, May 12, 1932

9:00 A. M. General Meeting___Jerusalem Temple
Mrs. Walter Jackson Freeman, *presiding*
10:00 to 10:50 } Special Round Table Conferences__
11:00 to 11:50 } _____ Jerusalem Temple
12:00 M. Buffet Luncheon____Jerusalem Temple
Tickets $1.00
1:00 P. M. *Trip to Oak Alley Plantation; visiting Spillway. Returning at 6 P. M. (Round trip $2 per person)
or
2:00 P. M. *Round-trip over Lake Pontchartrain, via New Bridges, ($2 per person)
or
2:30 P. M. *Trip to Versailes Plantation, Battle Field of New Orleans; Docks and Wharves (Round trip $1 per person)
or
2:30 P. M. *Delgado Museum and City Park; Newcomb Art School and Audobon Park (Round trip $1 per person)
or
2:30 P. M. *Mayan Exhibit____Tulane University (Round trip, 25 cents per person)
9:00 P. M. President's Reception and Ball_____ _____ Auditorium

Friday, May 13, 1932

9:00 A. M. *Trip to Gulf Coast—Leaving L. & N. Station at 9 A. M., returning to New Orleans at 6 P. M. (Round trip, including Luncheon and beautiful scenic drive along the coast, $6.00 per person)
10:00 A. M. Golf Tournament___Metairie Golf Club

* Transportation paid by individual. All trips start from Jerusalem Temple.

IN MILWAUKEE COUNTY

By MRS. J. C. SARGENT, *President*

Many people are asking the question "What are the purposes of the Woman's Auxiliary to The Medical Society of Milwaukee County?" By way of answer, let me quote first the article in our constitution which states these purposes:

ARTICLE II

The purposes of this Auxiliary shall be to extend the aims of the medical profession to all organizations which look to the advancement of health and education; to extend the aims and ideals of the medical profession to the public generally; to promote acquaintanceship among doctors' families in order to increase local unity and harmony; to assist in the social activities of state and county society meetings; and to do such work as may be approved from time to time by The Medical Society of Milwaukee County.

The Standard Dictionary defines the word "auxiliary" as "a person or thing which helps in a subordinate capacity." For us there are two very important words in that definition—"helps" and "subordinate," the full meanings of which we must thoroughly appreciate.

We are not an independent organization. It is not in our province to seek out unsavory conditions, take matters into our own hands, and clean house. Such activity belongs to the County Society. Our purpose is to stand by, ready and prepared to act as we may be directed by them. The County Society cooperates with all official and unofficial public

health agencies, and it is our aim only to lend assistance to such activities under the guidance of and privileged by the County Society.

With this as our principle, it can readily be seen that we can in no way anticipate into what channels our activities in future years will be directed. It seems, therefore, that this year, aside from our social activities, we should concern ourselves primarily with two main projects—that of self education, and that of lending ourselves to the Society to assist in furthering their project of lay education. With these aims in view, our Program Committee has arranged a series of talks which will give us a bird's eye view of some of the real problems facing the medical profession today, such as the ethics and economics of medicine, medical legislation, and state medicine.

Dr. Blumenthal has given us a picture of the relation of the medical profession to the public, touching on the value of periodic health examinations; Mr. Wiprud has outlined the work of the County Society; Mr. Crownhart has given us a glimpse into the business office of the State Society and the problems of medical legislation, and Dr. Sleyster has taken us on a verbal trip through the great American Medical Association's building in Chicago.

Our organization works through eight committees. The functions of the Membership, Social, Program, and Telephone Committees are self evident. Our Convention Committee is already busy laying plans for the entertainment of the wives of doctors coming to Milwaukee in September for the State Meeting. All items for medical publications or for the newspapers are handled by a Publicity Committee which checks constantly with the County Society office. The actual work of spreading medical education among the laity will be done through the Hygeia and Public-Relations Committees. The Hygeia Committee will not only promote the sale of Hygeia, but will place it at our expense in rural schools and social centers. The Public-Relations Committee will contact lay organizations with a view to supplying them with speakers from the County Society's Speakers' Bureau.

There will be many times when the Auxiliary will need to consult with the County Society on its problems, and for such emergencies the Society has appointed an Advisory Committee to the Auxiliary composed of three members,—Drs. R. W. Blumenthal, Ralph P. Sproule, and S. J. Seeger.

Such are the year's plans for our Auxiliary. It is our hope that we may never hinder, but, under guidance, always assist the County Society in its program for the advancement of health education.

NEWS ITEMS AND PERSONALS

Dr. William H. Neumann of Sheboygan returned on March first from New York City where he spent the month of February doing post-graduate work.

—△—

Dr. M. R. Wilkinson of Oconomowoc has been named a member of the advisory board to the Waukesha County Health Committee.

—△—

The Boscobel Community hospital, newly equipped, was formally opened early in March. Dr. F. S. Tuffley is in charge as physician and manager.

—△—

Dr. Arthur W. Rogers, Oconomowoc, Chairman of the Council, is enjoying a vacation trip to Mexico and Central America.

—△—

Dr. W. W. Bauer, a former health commissioner of Racine, has been promoted from assistant to director of the bureau of public health and instruction of the American Medical Association, Chicago. He succeeds Dr. John M. Dodson, resigned.

—△—

The February report of the Rock County Medical Clinic which was incorporated last September for the purpose of giving medical and surgical services to the needy of the county, shows that 71 new patients were admitted during the month, bringing the total of persons admitted since the opening to 390. The clinic was conducted at Beloit Municipal hospital.

Physicians in charge of the clinic during February were the following: Drs. T. F. Shinnick, J. W. Keithley, H. E. Burger, Benjamin Fosse, A. B. Zwaska, J. P. Allen and H. O. Delaney, all of Beloit.

—△—

Dr. and Mrs. Joseph Dean, Madison, were guests of their son, Dr. Joseph C. Dean, and his family in Philadelphia in March.

—△—

Dr. W. F. Lorenz, Madison, and Dr. Edward L. Miloslavich, Milwaukee, were among the speakers on the program at the annual convention of district attorneys held in Madison on March 18th.

—△—

Out of the city visitors to the offices of the State Medical Society in Madison included the following: Dr. Gilbert E. Seaman, Milwaukee; Mr. L. C. Austin, superintendent of Mount Sinai Hospital, Milwaukee; Dr. C. A. Armstrong, Prairie du Chien; Dr. Robert Riegels, Arlington; Dr. Gunnar Gundersen, La Crosse; Mr. Walter Drews, investigator for the State Board of Health, Milwaukee, and Dr. J. J. McCarthy of Sun Prairie.

—△—

Dr. and Mrs. K. W. Doege, Marshfield, sailed on March 17th for Bremen, Germany. During their

stay in Germany, Dr. Doege will attend a meeting of the German Surgical Society at Berlin of which he is a member, and a meeting of the German Society of Internal Medicine to be held at Wiesbaden. They will also spend some time at Hildesheim, Mrs. Doege's former home. They will return about May 15th.

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Dr. R. G. Osterheld, formerly of Stoughton, left on March 7th for Massachusetts where he has accepted a position with the state department of mental diseases. He will have offices at Touton, Mass. While practicing in Stoughton, Dr. Osterheld served as city health officer for two years, and has been on the board of trustees of the Lakeview Sanatorium, Madison.

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Dr. Otho A. Fiedler, Sheboygan, was the principal speaker at the March meeting of the Oney Johnston post of the American Legion, Appleton. Dr. Fiedler discussed the proposed health and accident insurance policies in lieu of government hospitalization.

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Dr. Ira F. Thompson, Racine, spoke before a meeting of Wisconsin public health nurses held in Madison on March 10th.

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A medical unit of the Wisconsin National Guard has been organized, according to a recent announcement by the Adjutant General's office, Madison. The unit will be known as ambulance company No. 184 of the 135th medical regiment. Dr. Albert R. Tormey, Madison, has been appointed to command the ambulance company. The 135th medical regiment is commanded by Col. W. F. Lorenz with Lt. Col. James Dean as executive officer and Major W. J. Bleckwenn as intelligence, plans and training officer.

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Dr. and Mrs. H. E. Purcell, Madison, returned on March 4th from Florida where they spent some time.

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Dr. John M. Dodd, Ashland, gave an address on "George Washington" before a meeting of the Ashland Rotary Club, Wednesday noon, March 24th. He illustrated his talk with pictures of historic interest taken while on a visit to the Washington country, including Valley Forge, the estate at Mount Vernon, the Washington tomb, Washington, D. C., Williamsburg where Washington was a member of the Virginia Assembly, and the lodge room in Alexandria where Washington presided as Master and from which he went forth to lay the corner stone of the National Capital.

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Dr. Harold J. Schilling of New Hampton, Iowa, has taken over the practice of Dr. E. A. A. Dunn of Platteville, who recently moved to Washington, D. C.

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"Proper Diets for Growing Children" was the subject of an address by Dr. Charlotte Calvert of the bureau of maternity and child welfare of the State Board of Health, before the annual meeting of public health nurses held in Madison in March.

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Dr. H. H. Morton, formerly of Cobb, Wisconsin, has moved to Dodgeville.

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Dr. J. C. Elsom of the University of Wisconsin spoke on "Physical Therapy" before a meeting of the Stoughton Rotary Club in March.

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The thirty-third annual meeting of the American Proctologic Society will be held at Memphis, Tenn., Friday and Saturday, May 6 and 7, with headquarters at the Hotel Peabody. For additional information address the Secretary, Dr. Curtice Rosser, 710 Medical Arts Bldg., Dallas, Texas.

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The Barron City hospital, which for sometime has been used as a nursing home, has been re-opened by the Barron Clinic after being fully equipped for hospital purposes.

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Dr. H. E. Kasten, Beloit, was the speaker at a meeting of the Delavan Rotary Club in March, his topic being "The Aftermath of the World War."

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"The Nurse's Relation to the Patient" was the subject of an address by Dr. D. D. Ruehlman of Monroe when he spoke at the graduation exercises for the nurses of Deaconess Hospital, Monroe.

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Dr. M. A. Bailey of Fennimore has announced his candidacy for mayor.

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MILWAUKEE

Dr. E. F. Barta was elected chief of staff of the Maternity Hospital and Dispensary Association at its meeting on March first. Other officers elected were Dr. G. A. Hipke, vice-chief of staff; Dr. J. V. Bolger, secretary, and Dr. Robert I. Hiller, treasurer.

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Mrs. Sarah J. Scollard, mother of Dr. William J. Scollard, died on Sunday, February 28th, at the home of a daughter, Mrs. Charles Tribe, at the age of 86 years.

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Easter Monday has been chosen by Miss Dorothy Dearholt, daughter of Dr. and Mrs. Hoyt E. Dearholt, as the date of her marriage to Mr. Timothy W. Goodrich, II of Hartford, Connecticut.

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Mr. Arthur Brooks Harlow of New York, son of Dr. and Mrs. George A. Harlow, will be married to Miss Alice W. Kelley, daughter of Mr. and Mrs. Frederick W. Kelley of Albany, New York, on April 2nd.

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Dr. and Mrs. Harry Sifton left Milwaukee on February 27th for Bermuda where they expect to spend about a month.

The medical profession of Milwaukee was invited to attend a lecture on "Bone Tumors," given by Dr. C. F. Geschickter, director of the Surgical Pathological Laboratories of Johns Hopkins University, Baltimore, Maryland, at Mt. Sinai Hospital on March fourth.

Dr. Geschickter is connected with the Cancer Foundation and also is an assistant to Dr. Joseph Bloodgood, professor of surgery at Johns Hopkins University, and an authority on cancer.

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Dr. John O. Dieterle left Milwaukee on February 27th on a two weeks' trip to New York and Pittsburgh.

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The Milwaukee League of Nursing Education held its February meeting at the Nurses' Home of the Milwaukee Hospital with Miss Evelyn Wood. executive secretary of the Nurse Replacement Service of the mid-west states, as the principal speaker. She spoke on the purpose and aims of the Nurse Replacement Service.

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The first article published anywhere on the medical exhibit to be shown at the Century Of Progress International Exposition to be held in Chicago, in 1933, appeared in the March issue of the official publication of The Medical Society of Milwaukee County, "The Milwaukee Medical Times."

This exhibit is in charge of Dr. Eben J. Carey, a member of the faculty of the Marquette University School of Medicine, and author of the article.

Dr. Carey's work, in connection with outstanding medical exhibits in this country during the past few years, has won for him national recognition. He was appointed executive-in-charge about a year ago.

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Dr. Edward Miloslavich spoke before the Business and Professional Women's Club on March 8th, on "Crime."

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The Educational Committee, at its meeting held on March 1, discussed at some length the proposed conference of hospital interns. They decided to send questionnaires to each intern in Milwaukee County requesting him to state what he would like to have discussed at this conference.

They agreed to sponsor another course in chest diagnosis this year, consisting of three sessions wholly under the direction of local physicians specializing in internal medicine.

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At a meeting of the membership committee, held in the Mariner Tower on March 2nd, the activities of this committee for the past year were reviewed. The committee decided to continue the practice of last year of considering applicants for membership in the Society, and of advising the Board of Directors as to whether, in their judgment, these applicants should be accepted as members.

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Members of the Health Department Advisory Committee, at their meeting held March 4th, considered problems which have arisen in connection with public health nurses and with school physicians.

Consideration was given to Dr. Koehler's request that an advisory board to the Isolation Hospital be appointed.

It was decided that all public health officers in Milwaukee County be invited to attend the next meeting of this Committee, to be held on May 25th.

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The Medical Economics Committee of the State Medical Society held a joint meeting with the Social Medicine and Medical Economics Committee of The Medical Society of Milwaukee County at the University Club on March 8th. Dr. R. G. Leland, director of the Bureau of Medical Economics, American Medical Association, met with the group.

The meeting was devoted to a discussion of the proposed survey in Milwaukee County.

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At the sixteenth annual clinical session of the American College of Physicians, was held in San Francisco, from April 4–8, Dr. Francis D. Murphy addressed the fifth general session, on April 6th, on the subject of "Primary (essential) Hypertension —A Clinical and Morphological Study of Three Hundred and Seventy-Five Cases."

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April second was the date set for the wedding of Mr. Arthur Brooks Harlow, son of Dr. and Mrs. G. A. Harlow, and Miss Alice Kelley, of Albany, N. Y.

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Dr. and Mrs. H. A. Sifton are enjoying a New York visit prior to sailing on the liner Monarch of Bermuda for a trip to Bermuda.

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The engagement of Mr. Erwin C. Ford, son of Dr. and Mrs. William B. Ford, and Miss Dorothy Ann Kramer, of Milwaukee, was announced by Miss Kramer's parents, Mr. and Mrs. John A. Kramer, early in March.

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Dr. and Mrs. William Jobse returned to Milwaukee on March 15th, from a three-months' visit with their daughter, Mrs. Arthur W. Hahn, at Pharr, Texas.

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Dr. A. R. Langjahr and his father, Mr. William Langjahr, of Plymouth, Wisconsin, have returned from a cruise to Cuba and the Bahamas.

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The Speakers' Bureau, sponsored by the educational committee of The Medical Society of Milwaukee County, was represented, during the month of March, by the following:

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On March 10th, Dr. D. W. Roberts addressed the Marquette Woman's League on "Keeping Mentally Fit."

At a meeting of the Parent-Teacher Association of the 27th Street School, held on March 14th, Dr. Robert W. Blumenthal spoke to the group on "The Common Cold."

Dr. C. C. Schneider appeared before the Parent-Teacher Association of the Green Tree School on March 14th. His topic was "Why the Foot is the Most Abused Part of the Human Body."

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The following health talks, sponsored by the State Board of Health, and delivered by Mr. Theodore Wiprud, executive secretary of the Medical Society of Milwaukee County, will be broadcast over the Milwaukee Journal Radio Station, WTMJ, during the month of April:

April 8, "Child Training"; April 22, "Lead Poisoning"; April 29, "Some Facts About Yeast".

The time allotted to these talks on April 1st and 15th has been given over to The Wisconsin Anti-Tuberculosis Association. Their subjects are as follows:

April 1, "Who was Robert Koch?"; April 15, "Tuberculosis Causes Tuberculosis—Every Case Comes From Another Case."

The talks on April 1st and 15th will be given by Mr. H. H. Jacobs, a member of The Wisconsin Anti-Tuberculosis Association staff.

All talks will be given from 3:45 to 4:00 P. M.

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Because of its popularity last year, and due to the many requests that it be repeated, the educational committee of The Medical Society of Milwaukee County is making definite plans for a course in "Chest Diagnosis," which will be given during the month of April.

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Dr. Elisabeth Seiler recently gave the following talks:

On February 14th, she addressed the Young Women's Christian Association's class in courtship on "How to Adjust One's Self to a Life Partner."

On February 18th, she spoke to the American Association of University Women, in Sheboygan, on "Psychology of Marriage."

On March 13th, she appeared before the Council of Jewish Juniors, at which time her topic was "Building Personality."

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At a meeting of the Committee of Hospital Representatives, held in the Mariner Tower on March 16th, the constitutions and by-laws of the various hospitals were compared, and problems of the hospitals and the medical profession discussed.

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The Health Council held a meeting on March 17th, at the City Club, at which time the activities of the Council's subcommittees,—the educational committee, child welfare and public nursing committee, and the health department advisory committee,—were reviewed. Communications, complimenting the Council on its activities in connection with the plan for the physical examinations of food handlers, were read.

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At a meeting of the Physicians' Service Bureau Advisory Committee, held in the Mariner Tower on March 17th, the Secretary gave a report of the number and types of calls made during the first two months of 1932, and the reference records of 1931, were presented for the consideration of the Committee.

The Bureau management was praised by the Committee for the efficient and impartial manner in which these records were handled.

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Dr. Edmund H. Mensing appeared before the Norwegian American Hospital Foundation of Chicago on March 16th and addressed them on the subject of "Indications for Jejunostomy," with demonstration of an experimental animal.

BIRTHS

A daughter to Dr. and Mrs. J. C. Griffiths, Milwaukee, on February 22nd.

A son to Dr. and Mrs. C. C. Schneider, Milwaukee, on February 28th.

A daughter to Dr. and Mrs. Ralph P. Sproule, Milwaukee, on March 1st.

A son to Dr. and Mrs. A. H. Lahmann, Milwaukee, on March 1st.

A daughter to Dr. and Mrs. J. B. Oliver of Ripon, March 16th, at Madison.

DEATHS

Dr. Robert Curtis Brown, Milwaukee, died at his home on February 26th, at the age of sixty-five years.

Dr. Brown, a native Milwaukeean, was a graduate of Columbia University College of Physicians and Surgeons in 1892. He was a pioneer in allergic diseases and published a number of papers on this subject, several of which were translated into French. During the World War he served as chief of medical staff at Base Hospital Number 22, France.

He was a member of the Medical Society of Milwaukee County, the State Medical Society, and was a fellow of the American Medical Association.

Besides his widow, Mrs. Katherine Butler Brown, Dr. Brown is survived by two brothers, Dr. Edward Brown of Northampton, Mass., and Howard Brown of Springfield, Mass.

Dr. J. H. Clark, Unity, died on March 6th.

He was born in the year 1855 and received his medical degree from Rush Medical College in 1883. He had practiced medicine for the past fifty years in that part of the state.

Dr. Gustav J. Kaumheimer, Milwaukee, died on March 12th at the home of his daughter, Mrs. Gebhard Koch, Milwaukee. Twenty-three hours earlier, at the Milwaukee Hospital, his wife, Jennie Starr Kaumheimer, had preceded him in death. Both Dr. and Mrs. Kaumheimer had long been in ill health.

Dr. Kaumheimer was born August 4, 1862, in Philadelphia. He came to Milwaukee when a young

man and graduated from University of Illinois in 1887. After serving internship at Cook County Hospital, Dr. Kaumheimer came to the Milwaukee County Hospital where he served for eighteen months. He was a member of the staff of Milwaukee Hospital for thirty-nine years and was for thirty-three years secretary of the staff. He was also consulting physician with the Deaconess and the Johnston Emergency hospitals.

Dr. Kaumheimer was an honorary member and a past president of the Medical Society of Milwaukee County and of the Milwaukee Academy of Medicine. He was also an honorary member of the State Medical Society.

Dr. and Mrs. Kaumheimer are survived by a son and daughter.

Dr. Charles Reineck, Appleton, died on March 4th at his home after a long illness.

Born in Millhome, Sheboygan County, February 7, 1880, he graduated from Oshkosh State Teachers College. He taught school for four years in Manitowoc County and then entered the Medical School of Northwestern University, graduating in 1906. Following internship he established his first office in Hortonville. Two years later he came to Appleton where he remained up to the time of his death.

He was a past president of the Outagamie County Medical Society and was a member of the staff of St. Elizabeth's Hospital.

He was a member of the Outagamie County Medical Society, the State Medical Society, and was a fellow of the American Medical Association.

Dr. Reineck is survived by his widow and two daughters.

He was buried with Masonic honors in Riverside Cemetery. Members of the Outagamie County Medical Society acted as guard of honor at the church.

Dr. James F. Turner, Waupun, died on March 4th at his home following a short illness.

He was born in Scotland, Jan. 18, 1846 and came to this country at the age of three years. At the time of the Civil War, he enlisted in Company D of the 10th Wisconsin Volunteers. He completed his studies at the University of Wisconsin in 1869 and in 1871 received his medical degree from University of Michigan Medical School. He practiced in Brandon, Wis., for eighteen years after which he moved to Waupun where he opened a drug store, doing office work and surgery for twenty years.

SOCIETY RECORDS

New Members

D. J. Ansfield, 238 W. Wisconsin Ave., Milwaukee.
W. A. Gleason, Osceola.
R. T. McCarty, Appleton.
C. K. Hahn, 1519 Washington Ave., Racine.
F. A. Wier, 313—6th St., Racine.
Verne W. Carlson, Lake Mills.
N. E. Bear, Monroe.
Warren T. Hagerty, 1209 Main St., Green Bay.
C. S. Wright, Indianapolis, Ind.
Russell F. Wilson, Beloit Municipal Hospital, Beloit.
Sylvester W. Welsh, 210 Main St., La Crosse.
R. W. Andrae, Plainfield.
A. A. Quisling, 123 King St., Madison.
D. E. Dorchester, Sturgeon Bay.
C. D. Jurss, 1354 N. 32nd St., Milwaukee.
N. F. Dettmann, 531 West Wisconsin Ave., Milwaukee.
Howard J. Kenney, Delavan.

Changes in Address

H. H. Morton, Cobb to Dodgeville.
R. G. Osterheld, Stoughton to Taunton, Mass.

Resignations

J. L. Fleek, Brodhead.
Edward Was, Oostburg.
E. H. Federman, Montello.

» » » CORRESPONDENCE « « «

"INDEED APPRECIATIVE"

Polk County Medical Society
Mr. Geo. B. Larson, *Secretary*

Frederic, Wisconsin, March 21, 1932.

Mr. J. George Crownhart, Secretary,
State Medical Society of Wisconsin,
Madison, Wisconsin.
Dear Mr. Crownhart:

We are indeed appreciative of the pamphlet summarizing the Poor Relief Laws of Wisconsin.

The Polk County Medical Society has been vitally interested in poor relief laws as they affect the physicians. We had our attorney make a particular study of the Wisconsin Poor Relief Laws and submit a brief of his findings, a copy of which I enclose in this letter. You will find that this brief, while it follows the same lines as the pamphlet prepared by the State Society, it is not nearly as complete.

Needless to say the legal expense involved together with the actual loss in money, due to failure to secure payment on non-resident poor, amounted to far more than the entire memberships' dues to the State Society for the year.

I would like to take this opportunity, Mr. Crownhart, to express the appreciation of our Society for the services rendered by the State Medical Society, not only in this instance, but constantly throughout the year. When you find some member or some So-

ciety is demanding "What good is the State Society doing me?—kindly refer him to this letter or to the Polk County Medical Society.

Very truly yours.

GEO. B. LARSON,
Secretary, Polk County Medical Society.

A. M. A. AT NEW ORLEANS

To the Officers, Fellows and Members of the American Medical Association:

The eighty-third annual session of the American Medical Association will be held in New Orleans, Louisiana, from Monday, May the ninth, to Friday, May the thirteenth, nineteen hundred and thirty-two.

The House of Delegates will convene on Monday, May the ninth.

The Scientific Assembly of the Association will open with the General Meeting held on Tuesday, May the tenth, at 8:30 P. M.

The various sections of the Scientific Assembly will meet Wednesday, May the eleventh, at 9 A. M. and at 2 P. M. and subsequently according to their respective programs.

EDWARD STARR JUDD, *President,*
FREDERICK C. WARNSHUIS, *Speaker, House of Delegates.*

Attest:
OLIN WEST, *Secretary*
Chicago, Illinois, March the fifth.

Suggested Standing Orders for Nurses Employed in Industry Issued by State Society

A set of suggested standing orders for nurses employed in industrial plants were issued by the State Medical Society late in March. The orders come as the culmination of several months of work by a special committee which included the following members: Dr. A. W. Gray, Milwaukee, Chairman; Dr. Edward W. Quick, Milwaukee; Dr. Wilbur L. Le Cron, Milwaukee; Dr. C. S. Beebe, Milwaukee; Dr. T. L. Squier, Milwaukee; Dr. Arthur G. Sullivan, Madison, and Dr. C. F. N. Schram, Beloit.

There are seventy-six nurses employed in industrial plants in Wisconsin and because the question has frequently arisen as to the scope of their work, one insurance carrier caused a bill to be introduced in the 1931 session of the legislature which proved to be objectionable to nurses and the medical profession alike. This bill was withdrawn and the insurance company suggested that the State Medical Society might well accomplish a worth while piece of work by preparing a set of suggested standing orders for nurses so employed. It was as result of that suggestion that the present orders were prepared.

The orders are not to be construed as authorization until signed by the plant physician, and members serving in that capacity will be forwarded copies of the pamphlet upon a post card request.

WORK OUTLINED

"No one appreciates better than physicians that there is a distinct place for nurses in industry," says the foreword of the bulletin. "A nurse so employed has a three-fold responsibility: (1) to her employer, (2) to the employee, and (3) to her profession.

"These interests are not conflicting ones when the employer and nurse have a complete understanding of the work which the nurse properly may be expected to perform. Essentially she is there to assist the plant physician, to render emergency first aid in his absence, to promote hygiene and sanitation in the surroundings, to promote safety that accidents may be prevented, and to minimize the loss of time due to illness and accidents. In fairness to herself, her employer and the employees, she must not assume responsibilities other than those outlined by her supervising physician, except those that she would accept were she practicing as a private duty nurse.

"Many seemingly minor injuries may bring serious results in their wake. Many seemingly minor symptoms may be forerunners, if unrecognized, of almost immediate disastrous results. If it is not possible that a physician always be present and see every case, he should be in close enough contact so that he, not the nurse, bears the responsibility for diagnosis and treatment of injuries and illness. Type of employment does not change what a nurse is licensed to do. And the fact that any untrained and unlicensed person may render first aid without compensation does not change the fact that a nurse employed in industry is working for compensation even though it be indirect, and she stands in the position of an 'expert' in the eyes of the injured or sick."

PRESS SERVICE OF STATE MEDICAL SOCIETY

No serum does so much for public health as printer's ink

CANCER AMONG WOMEN

Madison, Wis., March 3.—Cancer among women as a result of childbirths is being rapidly wiped out by the proper care of mothers, statistics just assembled by the State Medical Society of Wisconsin, and announced today indicate. Complete eradication upon discovery of the disease has been increased from ten per cent to seventy per cent, the tabulations show.

More than 900 physicians have furnished data upon which the bulletin issued today by the Educational Committee of the State Medical Society is based.

"For years mothers have been given special instructions on the care of their children and the special diet which is best for them and their infants," declares the bulletin. "This has had a tremendous beneficial effect upon the life of the child and its future health. At birth, silver nitrate is dropped into the eyes of the newly born. A few months later the infant is vaccinated against smallpox and protected against diphtheria. A great library of books has been written on the care of the child in the pre-school years and in the primary schools. But nothing has been done, practically, to teach the mother that her chief protection against cancer as the result of birth depends upon semi-annual examinations by a competent physician.

"To illustrate what education can accomplish for the protection of mothers, let us cite abscess of the breast. Forty years ago, more than fifty per cent of mothers who entered a surgical clinic with a tumor of the breast gave a history or exhibited the scar of a breast abscess, or what is called lactation mastitis. As years went on and more and more mothers were instructed by the nurses or the doctors how to keep the nipples clean while nursing the child, this uncomfortable, but not dangerous, complication has practically disappeared. In the same clinic today less than one per cent of women who have nursed children remember a breast abscess.

"The Educational effort of the American Society for the Control of Cancer in the past eighteen years has reduced the incidence of cancer of the breast from eighty to seventeen, and increased the eradication from ten to seventy per cent. For example, thirty years ago, when all women were uninformed and only reported to their doctor after they had observed a definite lump in the breast for months or years, the incidence of cancer was eighty and the probability of a relief ten per cent. During the past ten years there has been a tremendous change, largely due to correct information spread by the daily press. Women who have been informed to report the moment they feel or see anything unusual in one or both breasts, will have an incidence of cancer of seventeen instead of eighty per cent with the probability of relief in seventy instead of ten per cent. In a very large number, no operation will be necessary upon either breast. When a definite lump is found and an operation becomes necessary, in less than one-half will malignancy be discovered. In the others the breast will be saved. In the remainder the best opportunity to save life will be offered.

"When we can induce the press to give the same publicity to this correct information about cancer as the result of birth as has been given to cancer of the skin and mouth and breast, we will observe the identical results of a sharp decline."

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PARALYSIS

Madison, Wis., March 10.—Paralysis may come on like a thief in the night without warning, or it may be preceded by outward signs of long duration. Prevention of paralysis begins early in life.

These are statements taken from the weekly bulletin of the State Medical Society of Wisconsin issued today. The bulletin declared that one of the most common questions asked a doctor is whether a person who has been paralyzed will immediately recover.

"Paralysis is a general expression of disease of the nervous system regardless of the offending agent, or the point of its attack," declares the bulletin today. "The point of attack determines the kind of paralysis. If the assaultive agent works its destruction in the vital parts at the base of the brain, death ensues due to paralysis of the heart and respiration. If the cranial nerves are altered by any agent, there will be paralysis of some sort, depending on which nerves, or their cells of origin in the brain, are involved. Thus, if the optic nerve is involved, loss of sight occurs; if the eyeball is limited in its movement, one or more muscles to the eyeball is paralyzed; if the face is distorted because of failure of the muscles of one side to function, the seventh cranial nerve is sick (Bell's Palsy is not an unfamiliar term to the average person); deafness, or paralysis of hearing, often reveals disease of the eighth cranial nerve.

"Perhaps the most extensive results of disease occur when the spinal cord is affected.

"The agents that may cause paralysis are diverse. In persons of the middle and latter periods of life, disease of the blood vessels is the commonest cause of paralysis. Apoplexy is familiar to all, and is an ancient term to indicate paralysis as a result of hemorrhage or of the formation of a blood clot within a blood vessel of the brain. The usual manifestation is a paralysis of half of the body. In childhood and youth, infection is the commonest cause of paralysis. Specific infections such as infantile paralysis and meningitis affect limited portions of the spinal cord in the first case, and the coverings of the brain and cord in the second case. These are primary infections. Secondary infections of the brain are complications of middle ear and mastoid infection, measles and other contagious diseases.

"During these days of machinery and negligent motor driving, a common cause of paralysis at any age is injury to the head and back. Other causes relatively less frequent, but well known, are syphilis, alcohol, arsenic and lead poisoning and deficiency diseases (lack of vitamines or essential nutritive substances).

"Paralysis may come on like a thief in the night, without warning; and, on the other hand, it may be preceded by premonitory signs of long duration recognized by the physician. The early symptoms may be vague or meaningful. Since hardening of the arteries and heart disease are common in the later decades of life, prevention of paralysis begins early in life."

COUNCIL MEETS APRIL 23RD

The Spring meeting of the Council has been announced for Saturday, April 23rd. The meeting will be held at University Club, Milwaukee, and will open at nine o'clock Saturday morning. The business session will continue throughout the day.

THE JOURNAL BOOK SHELF

An Introduction To The Literature of Vertebrate Zoology. Compiled and edited by Casey A. Wood, M. D., LL. D., Collaborator, Division of Birds, Smithsonian Institute. Oxford University Press, London, 1931.

Health Protection for the Pre-School Child. A national survey of the use of preventive medical and dental service for children under six. A publication of the White House Conference. Price $2.50. The Century Co., 353 Fourth Avenue, New York, N. Y. 1931.

Allergy and Applied Immunology. A handbook for physician and patient on asthma, hay fever, urticaria, eczema, migraine and kindred manifestations of allergy. By Warren T. Vaughan, M. D., Richmond, Va. Illustrated. Price $4.50. C. V. Mosby Co., 3523 Pine Blvd., St. Louis, Mo.

Conquering Arthritis. By H. M. Margolis, M. D. Price $2.00. The Macmillan Company, New York, 1931.

Female Sex Hormonology. By William P. Graves, A. B., M. D. F. A. C. S., professor of gynecology at Harvard Medical School; surgeon-in-chief to the Free Hospital for Women and to the Parkway Hospital, Brookline, Massachusetts. 131 pages, with illustrations. Cloth, $3.50. W. B. Saunders Company, Philadelphia.

Living the Liver Diet. By Elmer A. Miner, M. D., Independence, Kansas. With introduction by William P. Murphy, M. D., instructor in medicine at Harvard Medical School, Boston. Price $1.50. C. V. Mosby Company, St. Louis, Mo. 1931.

Surgical Pathology of the Disease of Bone. By Arthur E. Hertzler, M. D. In the preface to this book the author states, "There is not, to my knowledge, any book which treats in a comprehensive manner the pathology of the disease of bones. That there is need for such a book is apparent to every teacher of surgery. The only excuse I have to offer for the publishing of such a book is that no one more capable has made any attempt to fill this very obvious need".

Infections of the Kidney. By Meredith F. Campbell, M. D., F. A. C. S., Price $3.00. Harper & Brothers, Publishers, 49 East 33rd St., New York.

A Textbook of Clinical Neurology. By Israel S. Wechsler, M. D., professor of clinical neurology, Columbia University, New York; attending neurologist, Neurological Institute and The Montefiore hospital, New York. Second edition, revised. Cloth, $7.00 net. W. B. Saunders Co., Philadelphia, 1931.

The Human Voice, Its Care and Development. Leon Felderman, M. D., price $2.50. Henry Holt & Company, One Park Avenue, New York City.

A Doctor of the 1870's and 80's. By William Allen Pusey, sometime president of the American Medical Association and of the American Dermatological Association. Charles C. Thomas, Publisher, Springfield, Ill. 1932.

BOOKS RECEIVED FOR REVIEW

United States Army X-Ray Manual. Authorized by the Surgeon-General of the Army. Second edition rewritten and edited by Lt. Col. H. C. Pillsbury, M. C., U. S. A. Flexible Leatherette, 500 pages, 228 illustrations. Price $5.00 net. Paul B. Hoeber, Inc., 76 Fifth Avenue, New York, N. Y.

Surgical Errors and Safeguards. By Max Thorek, M. D., surgeon-in-chief, The American Hospital, Chicago; attending surgeon, Cook County Hospital; corresponding member, Societe Des Chirurgiens De Paris, France; associate Royal Academy of Medicine, Torino, Italy. 668 illustrations. J. B. Lippincott Company, Philadelphia. Price $10.00.

Surgical Pathology of the Female Generative Organs. By Arthur E. Hertzler, M. D., surgeon to the Agnes Hertzler Memorial Hospital, Halstead, Kansas; professor of surgery, University of Kansas. 285 illustrations. J. B. Lippincott Company, Philadelphia.

BOOK REVIEWS

Any scientific publication reviewed in this column may be obtained for inspection. Orders for such inspection should be directed to the Medical Library Service, 424 N. Charter Street, Madison, Wis.

Emergency Surgery. By John William Sluss, A. M., M. D., F. A. C. S., Associate professor of surgery, Indiana University School of Medicine, zone surgeon, United States Fidelity and Guaranty Company; consulting surgeon, City Hospital, and John Walter Martin, M. D., assisted by David Hart Sluss, M. D., and Camilius B. DeMotte, M. D. Fifth edition, revised and enlarged. 797 illustrations, some in colors. Price $5.00. P. Blakiston's Son & Co., 1012 Walnut St., Philadelphia.

Emergency Surgery is a compact volume of some 862 pages. As is stated in the preface, it is a surgery for the general practitioner; written not to instruct his leisure hour, but in the hope some time to serve as a guide out of uncertainty in a time of stress. It is very thorough, taking one all the way through the surgical practices and giving well tried methods of their own experiences and of other masters in surgery. It is well written, brief, compact, and well organized. It should be a handy book for reference for the man who has to refer to a textbook in emergency. E. A. S.

A Non-Surgical Consideration of Prostatic Enlargement. Including a lecture on the myth of the bladder neck bar. By Edwin W. Hirsch, M. D., associate in urology, College of Medicine, University of Illinois; urologist, Englewood Hospital, Chicago; member, American Urological Association, Chicago Urological Society, and American Medical Association. Price $2.00. Bruce Publishing Company, Minneapolis and St. Paul, 1931.

The first part of the book deals with the various theories as to the cause of prostatic hypertrophy,

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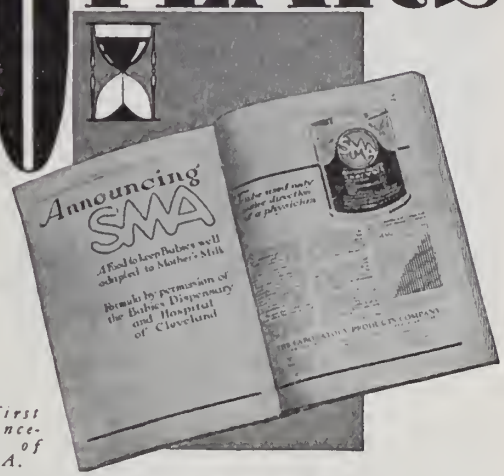

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and the author holds for the theory of infection which he regards as a fact and not a theory.

The entire book is composed of very positive statements, many of which are not held by urologists in general.

On the whole the book should not be held up as the last word in conservative treatment of prostatic enlargement and may be summarized as a radical viewpoint of the conservative. J. B. W.

Gynecology and Urology for Nurses. By Samuel S. Rosenfeld, M. D., F. A. C. S. Adjunct obstetrician and gynecologist Lebanon Hospital, New York City; lecturer in obstetrics and gynecology to Lebanon Hospital School for Nurses; diplomate of the American Board of Obstetrics and Gynecology. Price $2.00 net. William Wood and Company, New York. 1931.

The urological section of this book is rather short for such an extensive field of medicine. The anatomy, physiology, and pathology are clear and concise, giving sufficient information from the nurses' viewpoint. However, I do not believe there is sufficient instruction in nursing care of pre- and post-operative urological cases and the more common complications found in these cases.

From the gynecological standpoint, the book has been well given over to anatomy, physiology and pathology, as it applies to this special branch of medicine; the book gives all that one would expect a nurse to know in these respects. The author has failed in his purpose to show the art of nursing as applied to different gynecological cases. R. E. C.

Body Mechanics: Education And Practice. Report of the subcommittee on orthopedics and body mechanics. Robert B. Osgood, M. D., Chairman. White House Conference on Child Health and Protection. Price $1.50. The Century Company, New York, New York.

The term "body mechanics" is here used to designate postural pathology and hygiene. It is defined as the "mechanical correlation of the various systems of the body with special reference to the skeletal, muscular and visceral systems and their neurological associations." "Normal body mechanics may be said to obtain when this mechanical correlation is most favorable to the function of these systems." The subject is treated chiefly from the standpoint of posture and especially from the point of view of the importance of good posture for health. "Body carriage" would appear to be a better term to designate the subject under discussion than "body mechanics".

J. E. Goldthwait was largely responsible for first stressing in this country the importance of a good carriage of the body upon health, and this point of view has been further developed by several of his pupils and by others. The volume under review contains: (1) The report announced in the title; (2) A reprint of the pamphlet by A. Klein and L. C. Thomas on Posture and Physical Fitness published by the Children's Bureau of the U. S. Dept. of Labor., Bur. Pub. 205, 1931; (3) A reprint of a document of the Boston Public Schools (No. 6, 1930) relating to a course in physical education for the day elementary and day intermediate schools; and (4) various questionnaires sent out by the committee.

(1) The main report discusses the importance of posture and carriage of the body upon health, the extent to which various educational and health agents stress this importance and the need of greater educational facilities in this field.

(2) The reprinted Children's Bureau pamphlet is a reprint of a study of the relation of posture to health and of group training upon posture made upon 1708 elementary school children in Chelsea, Mass.

(3) The reprinted Boston School document describes methods directed toward improvement of body carriage in children, supplemental to the regular work in physical education.

The book is essentially rather a plea for greater attention to good carriage of the body from the standpoint of growth, development and health than it is a treatise on the mechanics of the human body. It is recognized that body posture or carriage is modified by build. The only illustrations in the book are silhouette illustrations from the Children's Bureau pamphlet on "excellent", "good", "poor", and "bad" posture in slender and stocky boys and girls. These are repeated twice. To the reviewer the "good postures" illustrated appear better than the excellent. From the standpoint of body action the latter appear too stiff. There is as yet far too little knowledge of the effects of body carriage upon growth, development and health to entitle one to be dogmatic on the subject. It appears reasonable, however, to assume that not only the beauty but also the health and efficiency of mankind would be improved by paying more attention to the carriage of the body during growth and development. C. R.B.

History of Medicine in the United States. By Francis R. Packard, M. D., Editor, Annals of Medical History. In two volumes. Paul B. Hoeber, Inc., New York. Price, $12.00.

I spent the winter of 1906–07 in Baltimore and, as I wandered out North Howard Strect one day, I came across a book store which was closing out its stock. On a stand outside the door was a lot of books priced at fifty cents, and one of these was Packard's *History of Medicine in the United States*, Philadelphia, 1901; in a moment ownership changed, and I became possessed of what was, for years, the source book of medicine in this country.

For a long time we have waited for some one to bring the medical history of the United States nearer modern times and now Dr. Packard has, once more, in these two volumes which bear the same title as the previous publication, made a notable addition to our knowledge. As the former volume was a source book, so these will, for years, be the source to which we turn for information in regard to the early epidemics, medical legislation, hospitals,

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and the men who took part in the development and improvement of medical instruction and practice in this country.

The story of the development of medical education is well told. Beginning with the anatomical lectures of William Hunter, and of Abraham Chovet, it brings out the work of William Shippen, John Morgan, Daniel Drake, the two Warrens, Thomas Bond, James Jackson, and many others in developing the various branches of medical instruction.

Among the notable events in medicine and surgery, two names, connected with Wisconsin, are mentioned—William Beaumont who did his fundamental work on the process of digestion at Prairie du Chien, and Erastus B. Wolcott, of Milwaukee, who did the first nephrectomy ever performed, though unaware while operating that he was removing a kidney.

The chapter on *The Medical Department of the Army*, by Col. P. M. Ashburn, and that on the *History of the Medical Department of the United States Navy*, by Lieut. Comm. Parsons, form interesting additions to the work by authoritative authors.

The closing chapter on *The Beginnings of Specialism in America* brings together facts which I am not aware can be found elsewhere.

A bibliography of the books and articles used by the author, and very complete indexes of personal names and subjects assist the reader in finding any desired information.

At the dedication of the Welch Medical Library, Prof. Sudhoff of Leipzig stressed the importance of collecting everything available in the history of medicine in this country. In a conversation with Prof. Welch, a short time since, he also voiced the same thesis. Dr. Packard has, in these volumes, given us a good start and also shown where further information is needed. W. S. M.

Psychology and Psychiatry in Pediatrics. The problem report of the subcommittee on psychology and psychiatry, Bronson Crothers, M.D., chairman. White House Conference on Child Health and Protection. Price $1.50. The Century Co., New York.

This report of the White House Conference subcommittee on psychology and psychiatry was the result of the efforts of a group of eminent physicians and one leading psychologist, headed by pediatrist, Bronson Crothers to solve the problem of who shall have priority rights in the guidance of the maladjusted child. The educator, the psychologist and the psychiatrist, looking at the problem from his own field of operation, has each claimed the problem as particularly his. The pediatrist and general medical practitioner have manifested an interest in the personality of the child, but have willingly and sometimes eagerly discharged their responsibility to the "problem child" by turning him over to the school authorities (educators and psychologists) or to the psychiatrist.

The subcommittee started out with the premise that doctors in general could occupy positions of "dignity and power" in any mental hygiene program. They thought a frank discussion of the problem might lead to a more intelligent understanding between general practitioners and pediatricians on the one hand, and psychologists and psychiatrists on the other. They more or less overlooked the very ancient rivalry between the psychiatrist and the psychologist, and put the psychiatrist on the wrong side of the fence! Aside from conferences, the questionnaire method was used—twenty-five psychiatrists, twenty-five pediatrists, ten psychologists and ten neurologists received letters suggesting specific topics to be discussed in order to get the opinions of the leaders in these fields. Excerpts from these letters are quoted in the report. Of course the conciliatory letters did not appear, and since the letters quoted, emphasized the importance of each writer's own field over all others, it would appear on the surface that it would be impossible for all these specialists to get together on a common footing. However, the subcommittee, after weighing all these opinions, were prepared to defend the statement that any "psychiatrically intelligent doctor" should be able to deal with the average problem child. They prefaced this statement with the premise that adequate medical care of the child cannot be given without intelligent attention to any intellectual and emotional difficulties which may be present. This would seem to the reviewer the most important statement made in the entire report, for it is a premise that should apply to every field of medical endeavor. But how can we hope for "psychiatrically-minded physicians" when only seventeen of sixty-four class A schools require one hundred or more hours of psychiatry, while twenty-one require less than fifty, and, of these, nine have none or only elective courses?

The book includes reports from typical groups such as the Merrill–Palmer School, Institute for Child Guidance (New York), the Essex County Juvenile Clinic (New Jersey), Institute for Juvenile Research (Chicago), and the Mobile Clinic of the State Psychopathic Hospital (Denver). The part taken by the psychiatric social workers is clearly stated by Mildred Scoville (now in administrative work with the Commonwealth Fund).

This report of White House Conference on Child Health and Protection will be of interest to the professional person concerned with development of child personality. M.G.M.

Surgical Pathology of the Skin, Fascia, Muscles, Tendons, Blood and Lymph Vessels. By Arthur E. Hertzler, M. D., surgeon to the Agnes Hertzler Memorial Hospital, Halstead, Kansas, professor of surgery, University of Kansas. 260 illustrations. J. P. Lippincott, Company, Philadelphia.

The discussion of ulcers and types is brief and to the point. Histological appearance is stressed.

An attempt is made to group the tumors of the skin and classify them according to their malignancy. General methods of treatment are sug-

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Viosterol

USE OF VIOSTEROL DURING PREGNANCY

To the Editor:—Please advise me whether administration of irradiated ergosterol to pregnant women could cause a premature calcification of the fetal head, resulting in dystocia, with possibly damage later to the child.

M.D., Waco, Texas.

J.A.M.A., Dec. 19, 1931, p. 1914

ANSWER.—There is no danger to mother or child from therapeutic doses of viosterol (irradiated ergosterol) given during pregnancy. In fact, such medication probably would be of advantage, owing to the excessive drain of calcium and phosphorus that takes place during this period. This medication is especially indicated in cases in which the intake of calcium compounds has been insufficient.

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MEAD'S VIOSTEROL IN OIL 250D, because of its well-known effect upon calcium absorption, is attracting increased interest among obstetricians for use during pregnancy. Aside from its mineral nutritional aspect, Mead's Viosterol in Oil 250D has a marked effect in lowering blood coagulation time. Samples and literature on request. Mead Johnson & Co., Evansville, Ind., U.S.A. Pioneers in Vitamin Research.

Please enclose professional card when requesting samples of Mead Johnson products to cooperate in preventing their reaching unauthorized persons.

gested. There are good references for further bibliography.

The diseases of the blood and lymph vessels are discussed in a brief, clear cut manner, linking the clinical picture with the pathological one.

The book lacks a sufficient discussion of specific treatment for the clinical practitioner. The photographs and photomicrographs, however, are excellent. A. C. T.

Primer On Fractures. By Cooperative Committee on Fractures, American Medical Association. Second Edition. As its name indicates, this book is a primer but like most primers it contains much information of fundamental importance.

It is a book which should be of value to the student as well as to a practicing physician. Only the treatment of the more common fractures is dealt with. The book is illustrated by many diagrams.

The essential points in the treatment of a given fracture are clearly outlined. There are many warnings as to what constitutes faulty treatment and good advice as to how errors may be avoided.

R. E. B.

Varicose Veins. With special reference to the injection treatment. By H. O. McPheeters, M. D., F. A. C. S., director of the Varicose Vein and Ulcer Clinic, Minneapolis General Hospital; attending physician New Asbury, Fairview and Northwestern Hospitals, Minneapolis. Illustrated with 62 halftone and line engravings. Third revised and enlarged edition. Price $4.00. F. A. Davis Company, 1914 Cherry Street, Philadelphia, Pa.

As a result of greater experience, more detail has been added in the description of the disease, types of instruments, and methods of treatment. Experimental work has also been added to explain some of the phenomena associated with varicose veins and varicose ulcers. There is a chapter on pathological work on biopsy specimens, also a new chapter discussing the causes of failure in the injection treatment, together with a chapter on elephantoid states due to lymphatic obstruction.

The book is very well written and illustrated, and presents a clear and concise picture of the treatment of varicose veins. E. R. S.

Physicians Manual of Birth Control. By Antoinette F. Konikow, M. D., 1931, The Buchholz Publishing Co., 1501 Broadway, New York City.

In this volume of 230 pages the author has quite adequately described the various methods of birth control in common usage with the advantages and disadvantages of each. The subject is discussed in a clear, concise manner and is pleasingly free of the atmosphere of propaganda which seems to pervade most publications on this topic. While some may disagree with the author's choice of certain methods of birth control in isolated instances, in general her conclusions are those that are most widely accepted at present. The book can heartily be recommended to physicians as an excellent source of practical information on this most important subject. J. W. H.

DOUBLE VAGINA

(Continued from page 257)

On examination of the vagina, it was noted that there were two vaginas of about the same size, for the septum was medially placed and not very mobile as it was about 0.2 centimeters in diameter; it began at the fossa navicularis and extended to within one centimeter of the bifurcation of the cervices. Each cervix was about 1.5 cms. in diameter with openings that permitted a 12 French probe, but the left cervical canal united with the right cervical canal at 1.5 cms. from the left cervical orifice.

At operation, under spinal anaesthesia, the vaginal septum was excised and sutured by a running lock stitch so as to convert both vaginas into one. The two cervices were cut through so as to make one common opening into the fundus of the uterus.

At the first menstrual period following operation there was profuse bleeding causing patient to be in bed two days, but periods have been normal and regular since.

THERAPEUTIC NOTES

New and Nonofficial Remedies

In addition to the articles previously enumerated, the following have been accepted by the Council on Pharmacy and Chemistry of the American Medical Association:

Abbott Laboratories:
- Bismo–Cymol.

Calco Chemical Co., Inc.:
- Trichlorethylene–Calco:
  - Tubes Trichlorethylene–Calco, 1 cc.

Riedel–de Haen, Inc.:
- Decholin:
  - Decholin Tablets, 3¾ grains.
- Decholin–Sodium:
  - Ampoules Solution Decholin–Sodium, 5 per cent, 10 cc.
  - Ampoules Solution Decholin–Sodium, 20 per cent, 10 cc.

E. R. Squibb & Sons:
- Iodobismitol–Squibb.

Nonproprietary Articles:
- Sodium Iodobismuthite.
- Trichloroethylene.

The following article has been exempted and included with the List of Exempted Nonmedicinal Articles (New and Nonofficial Remedies, 1931, p. 481):

Robert McNeil:
- Lubricant–McNeil.

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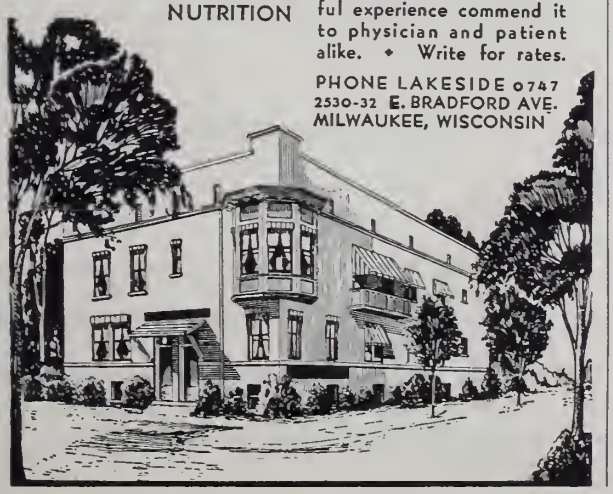

LET'S TALK OVER THE BIFOCAL SITUATION...

AND let's get right down to brass tacks about it—Bifocals come and go—but what is the one outstanding feature of any bifocal that enjoys lasting popularity? Invisibility, of course. Invisibility is what appeals to modern American men and women—but you and they want maximum optical performance too.

NOW here's a bifocal—"The Orthogon D"—that gives super performance and for added good measure is incomparably invisible. Its segment is made from Bausch & Lomb Nokrome glass—consequently it is absolutely free from color aberration. It is ground according to the patented Orthogon Series of Curves—astigmatically corrected to the minimum amount of marginal astigmatism. And what's more—"Orthogon D" is available at the lowest price ever asked for a bifocal containing all these features.

TRULY it is the answer to your bifocal problem. It's available in Soft-Lite too! Send for the booklet —"Orthogon D" The Modern Bifocal.

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Patent Medicines and the Public Health*

By ARTHUR J. CRAMP, M. D.
Director Bureau of Investigation
American Medical Association

In spite of the financial depression, the American public, this year, will spend approximately $200,000,000 on "patent medicines". John Doe little realizes when he pays a dollar for a bottle of "Dr. Quack's Quick Relief" that more than fifty cents of his dollar has been expended in the manufacturer's effort to convince him that he is suffering from some ailment for which the "Quick Relief" is said to be a sure cure. The cheapest thing about a "patent medicine" is the drugs that compose it; the most expensive thing is the advertising which sells it.

Mr. Barnum said that the public likes to be humbugged. It probably doesn't. But it *is* humbugged to the extent that it lacks knowledge, and in the realm of therapeutics, the public's lack of knowledge is great. Voltaire said that the charlatan was born on the day that the first fool met the first knave. But the hisory of quackery proves that quacks can get rich on wise men as well as on fools. It is not a lack of brains that breeds credulity but a dearth of knowledge. It was Aristotle who said that "Incredulity is the source of all wisdom".

Whenever the medical profession points out the dangers inherent in "patent medicines", the cry is raised that its criticism is inspired by selfishness, that the remedies are competitors of the doctor, and that their sale diminishes his income. Nothing is farther from the truth. Of a hundred people who read, say, a "kidney pill" advertisement and are frightened into the belief that a pain in the lower back means kidney disease, more than half of them will go to their family physician rather than to the drug counter. If the physician's attitude toward "patent medicines" were prompted by commercial considerations, he would say to the medicine maker: "Go the limit; the more victims you get, the more patients I get".

What we colloquially call "patent medicines" are not patented at all. Patent means open: without secrecy. And without secrecy, you have no mystery. Not being able to patent his product, the maker of so-called patent medicines coins a fancy name for his mixture and gets a trade-mark on that name. This gives him what is essentially a perpetual monopoly in the use of the name. The so-called patent medicine is a proprietary medicine. One buys a name, not a thing. From a business standpoint, the least important thing about a "patent medicine" is its composition; the most important is its name.

The testimonial is the sheet anchor of the "patent medicine" business. It is a human characteristic to give credence to testimony. However, testimony on subjects beyond our knowledge is not competent. Most "patent medicine" testimonials are documentarily genuine, but incompetent.

Medicaments are a special class of merchandise. The seller of general merchandise has nature as an opponent—wear and tear. The seller of drugs has nature as an assistant, for the tendency of the body usually, is to get well. When John Doe feels "out of sorts", he will, in all human probability, be all right again in a few days, whether he does something or nothing for his condition. If, in the meantime, he takes a bottle of "patent medicine", he will insist that his recovery was due to the medicine. As a matter of fact, in more than eight cases out of ten, the cure was brought about by nature. John mistakes a sequence of events for cause and effect.

Modern advertising differs from that of a generation ago. It strives to *create* demand rather than *fill* demand. It is the art of making people want what they otherwise would not know about. There may be a possible economic excuse for such advertising of general merchandise, but there is no excuse for making well people think they are sick for the purpose of stimulating sales of "patent medicines." The greatest indictment against the "patent medicine" business is not that "patent medicines" may contain poisonous or habit-forming drugs, but that it makes a nation of hypochondriacs, and does so deliberately for the purpose of stimulating the use and sale of drugs.

* Abstract of an illustrated address before the Woman's Auxiliary to The Medical Society of Milwaukee County, 1932.

Basic Science Board Examination Questions, December, 1931

PHYSIOLOGY

Answer any seven questions.

1. Discuss briefly the respiratory function of the blood.
2. What is the modern theory of renal secretion?
3. What are the functions of the bone marrow?
4. a-What is meant by the fragility test of red blood cells?
   b-Give the meaning of increased fragility of red blood cells.
5. a-What is meant by alkali reserve?
   b-Under what conditions is it deviated from normal?
6. a-What is the function of the cortex of the suprarenal gland?
   b-What practical uses are made of suprarenal gland substances?
7. Give the principle underlying the practical application of the electrocardiogram.
8. What is the action of insulin in the diabetic patient?

PHYSICIANS' EXCHANGE

Advertisements for this column must be received by the 25th of the month preceding month of issue. A charge is made of $2.00 for the first appearance of copy occupying 1 inch or less of space and $1.00 for each succeeding insertion of the same copy. Kindly accompany copy with remittance to cover number of insertions desired. Advertisements from members of the State Medical Society will be accepted without charge. Such copy will be taken out after its second publication unless otherwise requested. Where numbers follow advertisements replies should be addressed care Wisconsin Medical Journal.

WANTED—Surgeon with 16 years experience, 4 years postgraduate work in Europe, desires group appointment or association with busy surgeon or general practitioner. Would consider purchase of practice. Address No. 867 in care of the Journal. AMJ

POSITION WANTED AS LOCUM TENENS. Will finish interneship July first. Available July, August and first two weeks in September. First two years at University of Wisconsin, graduate University of Kansas, and licensed in Wisconsin. Address No. 868 in care of the Journal. AMJ

OFFICE ASSISTANT DESIRES POSITION. Two years experience as office assistant. Particularly qualified as physiotherapist and x-ray technician. Has kept books and is typist. Willing to go anywhere in state. Address Miss Helen MacKaben, 710—3rd Ave., Wisconsin Rapids, Wis.

FOR RENT—Medical group to sublet modern office space on Wisconsin Avenue in Milwaukee, completely equipped, access to clinical and x-ray laboratory. Address No. 865 in care of the Journal. MAM

WANTED—Locum Tenens work by experienced physician; available now for short or long period; licensed in Wisconsin; reference furnished; will not compete. Address No. 851 in care of Journal.

FOR SALE—Doctor's home and office with equipment and drugs for sale or rent. Inquire Mrs. F. L. Griswold, Mazomanie, Wisconsin. AMJ

WANTED—Eye, ear, nose and throat practice, in or near Milwaukee. Address Number 864, in care of the Journal. MA.

WANTED—Used x-ray lead protective screen. Must be in good condition. Address No. 862 in care of the Journal. FMA

FOR SALE—Unopposed practice, small village in good dairy section. For price of drugs, office furniture, and some equipment. A bargain for quick sale. Will introduce. Specializing. Address Number 861 in care of the Journal. FMA

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3. Describe the oral cavity.
4. Give a general description of the osteology of the pelvis.
5. Describe the external carotid artery.
6. Describe the organ of vision.
7. Describe the pancreas.

PATHOLOGY

1. Discuss the etiology of carcinoma.
2. Describe the formation of granulation tissue.
3. Discuss thrombosis.
4. What changes are found in the pancreas in diabetes mellitus?
5. What changes are produced in the body as the result of the inhalation of carbon monoxide?
6. Define:
   1. Edema.
   2. Exudate.
   3. Sclerosis.
   4. Fibrin.
   5. Naevus.
   6. Cicatrix.

DIAGNOSIS

Answer any five of these questions

1. Name six most frequent causes of hemoptysis in relation to the respiratory system.
2. Bradycardia: What are some of the significant factors?
3. Hypertension: What diagnostic significance would you consider?
4. Diagnose by symptoms a case of mushroom poisoning. What antidote? (Antidote may be omitted if you wish as it does not come under diagnosis.)
5. What do you understand about the metabolic test in goitre cases? How would it govern your action in a given case?
6. Enumerate the changes in the microscopic blood picture in the different anemias.
7. What information is acquired, of diagnostic value, in having the "blood chemistry" of a patient? What are your expectations?

State Society Issues Summary of Wisconsin Poor Relief Laws Affecting Care of the Indigent Sick

Because of the extremely confused situation with reference to authorization for care of the indigent sick in the state-at-large outside of Milwaukee County, the State Medical Society during March published a digest of poor relief laws as they affect the care of the indigent sick in the state-at-large. The digest was not forwarded to members in Milwaukee County because of exemptions in the law for that County and the separate system that is there established. Offering to supply additional copies that members might place them in the hands of public officers charged with the relief of the poor, upwards of 1,000 additional copies were mailed out within two weeks following the publication of the sixteen-page pamphlet. The digest was made by the legal department of the Society and bears the approval of the Attorney General of the state.

That the digest fills a need of long standing was the comment of members writing to State Society office. Following are some of the comments:

"I happen to be a member of the Board of County Supervisors in Janesville at the present time and this is getting to be a very important problem with the Board of Supervisors. Many of them have not these points clearly in mind and I am wondering if you would be in a position to send 52 copies so that each one of the Supervisors could have one of the pamphlets. I think it is one of the clearest, concise pamphlets that I have seen in a long time on this matter."—Dr. Wayne A. Munn, Janesville.

"Your digest is timely for us."—Dr. Geo. H. Conklin, Health Commissioner, Superior.

"The booklet is, without question, very much needed and ought to prove a very real contribution in this field."—Mr. A. W. Williams, General Secretary, Wisconsin Conference of Social Work, Madison.

"I think the booklet will be of great assistance to help us with the supervisors."—Dr. G. R. Love, Summit Hospital, Oconomowoc.

"This should be a great help to doctors especially this year as my experience is that doctors and town officers know very little about this."—Dr. F. E. Butler, Menomonie Clinic, Menomonie.

"Thanks very much for your copy relative to poor relief. If it is not asking too much I would like ten or twelve additional copies for distribution."—Dr. T. C. H. Abelmann, Watertown.

"I wish to thank you for sending me a copy of the summary of Wisconsin poor relief laws. It would facilitate matters for me if you would send me three more copies which I could give to the chairmen of the towns here in order that they may be informed regarding this troublesome question."—Dr. B. H. Dike, Owen.

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"A valuable work and I congratulate you."—Dr. John M. Dodd, Ashland.

"I have just finished reviewing the summary of Wisconsin laws, Supreme Court decisions and Attorney General Rulings relative to the care of indigent persons who are ill and feel you are entitled to a great deal of credit for this very readable, useful compilation. Heretofore we have always assumed that certain procedures were necessary and lawful but now we can quote court decisions and the attorney general rulings which will be much more satisfactory."—Mr. L. W. Hutchcroft, statistician, State Board of Health, Madison.

"The Summary of Wisconsin Poor Relief Laws has just arrived and it answers very fairly and clearly so many of the questions which have had to be answered by a guess in the past. I feel that this tract should be of great value to every county board member in the state, and I wish it were possible for each to be supplied. I do not know how many extra copies each of us is entitled to, but I shall be pleased to have my quota and will be responsible for getting them distributed as widely as I can among the chairmen of the towns with whom we have professional relations."—Dr. J. Fred W. Clark, Laona.

"If possible we would like to get enough extra copies to give to the various supervisors,—between forty and fifty. All the men here are pleased with the summary."—Dr. J. A. Kelly, Chippewa Falls.

"As chairman of the local Red Cross chapter and doing county relief work, I have difficulty in convincing town officers that they are required by statute to give relief to the needy. I could use eight or ten copies of the digest you recently sent out and wish to have them to distribute as indicated."—Dr. F. A. Southwick, Stevens Point.

"This is a very helpful booklet. I am sure the work represented in it will be appreciated by the doctors of the state."—Dr. J. W. Lowe, Merrillan.

PHYSICIANS LICENSED AT JANUARY MEETING

Name	*School of Graduation*	*Address*
Damp, Orville E., M. D.	Marquette Medical School	Mil. Children's Hosp., Milwaukee, Wis.
Davis, Milton D., M. D.	Northwestern Medical School	Milton, Wis.
Dollard, James E., M. D.	Wisconsin Medical Univ.	Mil. Children's Hosp., Milwaukee, Wis.
Golley, Dean Willett, M. D.	Wisconsin Medical Univ.	Hospital for Insane, Mendota, Wis.
Hutter, Adolph M., M. D.	Wisconsin Medical Univ.	Wis. General Hosp., Madison, Wis.
Lando, David H. Jr., M. D.	Illinois Medical Univ.	3721 N. Farwell Ave., Milwaukee, Wis.
Lawler, Edward M., M. D.	Marquette Medical Univ.	Mil. Co. Hosp., Wauwatosa, Wis.
Lee, Howard James, M. D.	Wisconsin Medical Univ.	Wis. General Hosp., Madison, Wis.
McDonough, Kenneth B., M. D.	Wisconsin Medical Univ.	Wis. General Hosp., Madison, Wis.
Sannes, William A., M. D.	Cincinnati Medical Univ.	317 State St., Madison, Wis.
Skibba, Joseph Phillip, M. D.	Marquette Medical Univ.	Antigo, Wis.
Urben, Walter John, M. D.	Wisconsin Medical Univ.	New York Post Grad. Hosp., New York City, N. Y.

BY RECIPROCITY

Name	*School of Graduation*	*Address*
Cline, Frances A.	Univ. of Ill. Medical School	210 Princeton Ave., Madison, Wis.
Edwards, Richard G.	Univ. of Minn. Medical School	1714 St. Clair Ave., Sheboygan, Wis.
Farrell, Hubert J.	Marquette Medical School	1340 N. 55th St., Milwaukee, Wis.
Hedin, Raymond F.	Univ. of Minn. Medical School	Taylor Falls, Minn.
Leininger, Alfred T.	Rush Medical School	Rockford Hosp., Rockford, Ill.
Margoles, Louis	Univ. of Minn. Medical School	935 Goodrich Ave., St. Paul, Minn.
Settle, Russell O.	Kansas Medical School	14½ Mill St., Waupun, Wis.
Shapiro, Herman L.	Loyola Medical School	6838 East End Ave., Chicago, Ill.
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Stiles, John A.	Wisconsin Medical School	Wisconsin General Hosp., Madison, Wis.
Tillotson, Bradley P.	Northwestern Medical School	Lake Geneva, Wis.
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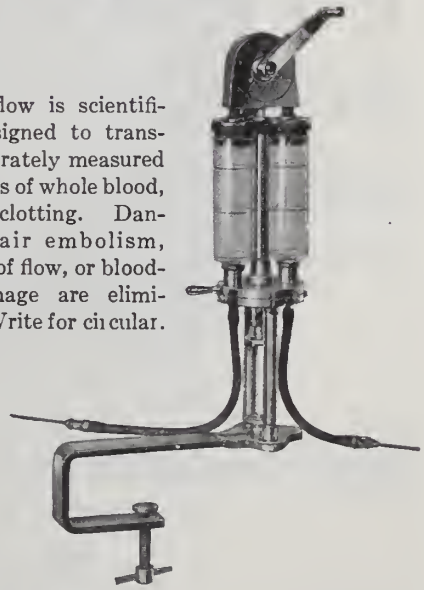

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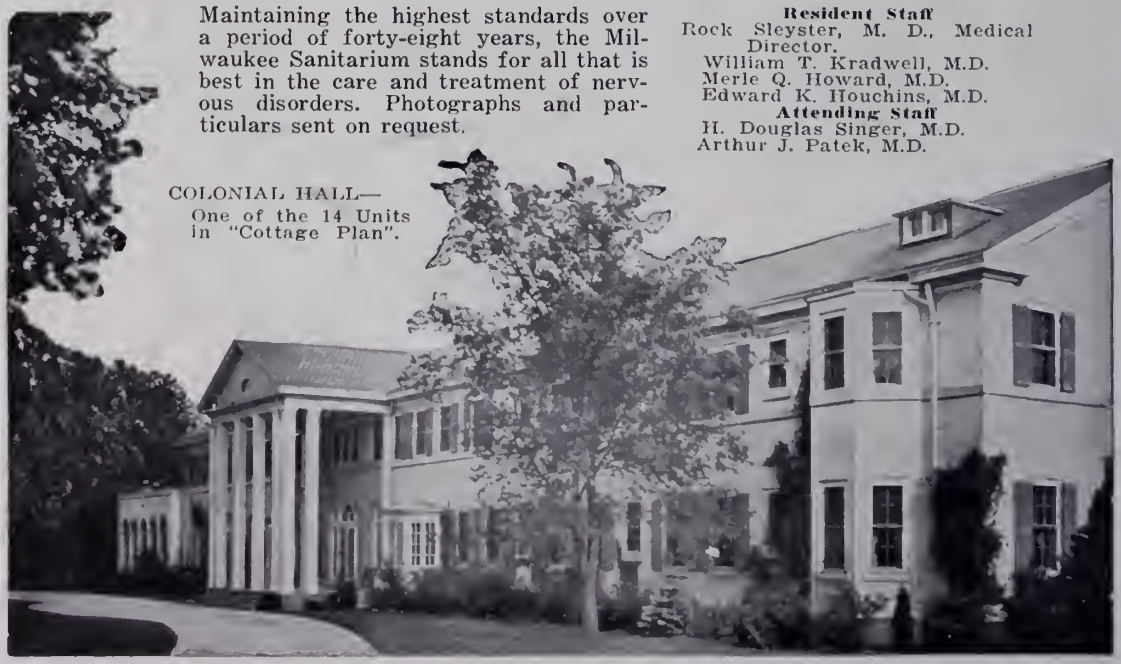

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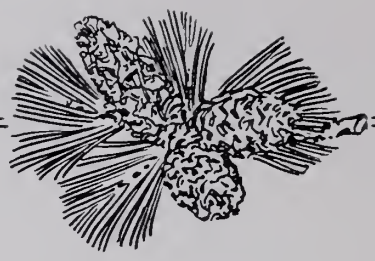

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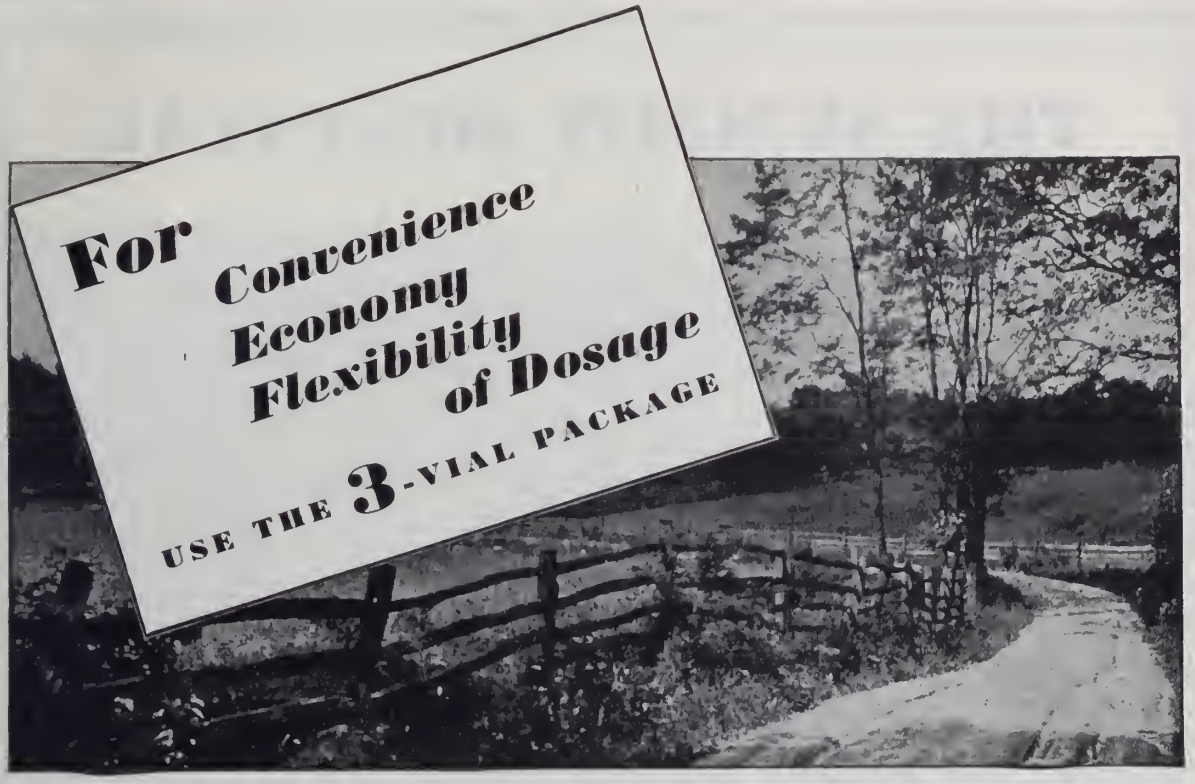

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What Every Doctor Should Know About Pathology*

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When the trusteees of the Johns Hopkins University and the Johns Hopkins Hospital in 1883 turned to the selection of a pathologist for that hospital, who was also to be a professor of pathology, they did not know of a pathologist in this country fit to take the place. They turned to Germany, to Cohnheim, who did not hesitate to tell them that there was at least one in this country who had sufficient training and standing, and who had been trained in Cohnheim's laboratories, and who had already made a place for himself in New York.

Therefore, fifty years ago there were not only very few pathologists in this country, but very few doctors who knew anything about pathology.

If someone were to be selected today to take the chair of pathology formerly held by Welch and now by McCallum, there would be much less difficulty than fifty years ago, and there are a large number of pathologists in this country occupying similar positions in the medical schools of our Universities. During these fifty years, there have been trained and developed in this country not only pathologists competent to teach pathology, but the majority of the younger generation know a great deal about pathology. Unfortunately, although they know very much more, not every doctor knows enough about either general or special pathology today, to meet the demands of the general or special practice of medicine.

It is a pretty difficult problem today to agree among ourselves as to exactly how much general and special pathology should be taught in the medical schools, and it is a much more difficult undertaking to describe to the general profession what every doctor should know about pathology. I will confine myself to special pathology, and in this domain to the pathology of local lesions which may or may not be malignant, and largely to microscopic pathology of such lesions.

Cancer and local lesions that are not cancer, whether they precede cancer or not, are less and less frequently seen today by the physician in a stage in which they can be recognized clinically, or by the surgeon when they can be recognized by their gross appearances when exposed at operation.

In the beginning most malignant diseases were differentiated from each other and from benign conditions by their clinical appearance, or, at autopsy, without the aid of the microscope. Velpeau, the outstanding French surgical pathologist, wrote his first book on diseases of the breast without the aid of the microscope. Velpeau diagnosed from clinical appearances and gross pathology. By the time of the second edition of his book, the microscope was in use by pathologists, and Velpeau bitterly complained and criticized the mistakes in diagnosis made by these early microscopic pathologists.

Halsted, Senn, Fenger, and Warren, were the last of the surgical pathologists in this country who depended upon naked-eye diagnosis to differentiate the benign from the malignant at the exploratory incision.

At least in this country, the routine employment of frozen sections as the most important method of differential diagnosis during the operation, began in the Mayo Clinic. Many trained surgical pathologists did not accept this practice of the Mayo Clinic until 1915, and today the practice of employing frozen sections in the operating room during the operation is accepted in the minority and not in the majority of the operative clinics in this country or the world.

* Presented before 90th Anniversary Meeting, State Medical Society of Wisconsin, Madison, Sept., 1931.

CANCER—A MICROSCOPIC DISEASE

Therefore, first, from my studies, I am forced to the statement that the most important thing that every doctor should know about pathology is that cancer is becoming so rapidly a microscopic disease; that all patients, whose local lesion has not assumed the definite clinical picture of cancer, have a better chance of a cure without mutilation, if the diagnosis is made at the operation from frozen sections examined by a competent pathologist. If every member of the medical profession could be convinced of this, the introduction of microscopic pathology into the operating room as an integral part of the operating-room technic, would be accomplished more quickly and the entire medical profession would be in better position to meet the new demands of an enlightened public who come under their observation either for a diagnostic survey when apparently well, or after the first warning from their local trouble.

Before giving the evidence which favors the introduction of frozen sections into the operating room, and before illustrating this evidence with lantern slides, I wish to record here that there are many other old and new diagnostic technics with which every physician in the practice of medicine, whether general or special, should be familiar.

Many of these diagnostic tests can be made by technicians, such as the basal metabolism test, blood counts, blood chemistry, urinalysis, blood pressure, kidney function. Other tests can only be made by the specialist, for example, examination with the ophthalmoscope, laryngoscope, etc.; the interpretation of the x-ray films which can be taken by the technician; the interpretation of the microscopic section; the interpretation of the electrocadiogram. Not every doctor is expected to make, or even interpret these laboratory tests, but he should know when these tests must be made, because, unless they are made in time, their diagnostic value becomes of lesser and lesser value to the patient. In spite of the great importance of the routine clinical history and careful physical examination, the importance of these laboratory tests and special examinations increases as patients seek advice the moment they are warned, or report annually or semi-annually for a diagnostic survey.

Today, more than ever before, the expertness of the surgeon, the completeness of the preoperative preparation, and the reduction of the dangers of anesthesia and shock, may be effaced because of an incorrect preoperative or operative diagnosis, due to the fact that frozen sections were not made to direct the character and extent of the operative procedure.

CERVIX AND LINING OF THE UTERUS

In presenting the problem of "What Every Woman Should Know For Her Protection Against Cancer," Wednesday noon at the Women's Club luncheon, it was stated that the majority of obstetricians and gynecologists in this country are of the opinion that the greatest protection for women who have borne children is a semi-annual pelvic examination. This means that in these women cancer of the cervix and lining of the uterus will only be seen at a stage in which it will be possible to recognize it only by microscopic study of pieces of tissue removed, and these few cases of early cancer will have to be picked out of hundreds in which the lesion of the cervix, or the changes in the epithelial lining of the uterus, are not malignant.

The major part, therefore, of the diagnosis which will afford the greatest protection and lead to the greatest probabilities of a cure if malignancy is present, will depend upon the microscope.

BREAST

The greatest difficulty in the routine examination of the breasts during the annual or semi-annual diagnostic survey, or when women report after the first sign of trouble, will be to differentiate by palpation and transillumination the lump that should be explored from the lump which is only part of a lumpy or shotty breast which need not be explored.

Today, the most experienced surgical pathologists know the danger of attempting to differentiate the benign from the malignant tumor of the breast by its naked-eye appear-

ance. Yet, up to 1915, this was the routine procedure, and there were few mistakes.

Not only do we agree on the difficulty of deciding whether a lump should be explored or not and upon the danger of depending on gross pathology, but recent experience is teaching us the great difficulty of deciding, from frozen sections in the operating room, between the benign and malignant tumor of the breast. In most clinics in which the surgeon has had considerable experience in the diagnosis of breast tumors and the pathologist is of the average training in the diagnosis from frozen sections of fresh tissue in the operating room, and both are doubtful as to the malignancy of the tumor, it seems safer to remove the tumor only and submit the permanent sections to one or more of the most experienced microscopic diagnosticians of breast lesions. This is based upon the fact that in recent years, when this happened, the tumor has usually been benign. In former years, the most common mistake, when surgeons depended upon gross diagnosis only, was the removal of a malignant tumor on the diagnosis of benignancy. Today the most common mistake, after careful study of the frozen sections in the operating room, is to perform the complete operation for cancer when the lesion is not cancer. The interest of every doctor in problems of this kind will be helpful in solving the problem, and every doctor who refers breast tumors to surgeons should be familiar with these possibilities of mistakes.

BONE

Neither the x-ray, nor the frozen sections in the operating room have solved the problem of the differential diagnosis between benign and malignant lesions of the skeleton.

Let me make a brief statement of what I propose to amplify in the clinical pathological conference with pathologists and radiologists Friday morning September 11th. From our studies of a vast material of benign and malignant conditions of the bone which have accumulated in the clinics in the past twenty-five to forty years, students are attempting to formulate certain definite rules of procedure in the diagnostic study and other definite rules which seem best to follow in attempting treatment.

In the first place, the x-ray of the bone lesion can be submitted to consultant radiologists, while the diagnostic survey is being completed. Experience has clearly demonstrated that the neglect of a single item of the diagnostic test is dangerous. During this period of study, if there is the least suspicion of malignancy, the bone affected can be put at rest and given deep x-ray therapy. This in some instances furnishes diagnostic clues for or against malignancy. If the Wassermann is plus, there should be no operation on the bone lesion without preliminary antiluetic treatment. In many cases, not only must an operation be performed, but the nature and extent of this operation cannot be settled until the diseased area is exposed and tissue taken for microscopic sections. When even the most experienced pathologist of bone lesions is in doubt as to malignancy, it would be wiser not to perform the radical operative procedure until after sections had been submitted to other pathologists.

All of these studies in the past few years have shown that, as cancer becomes more and more a microscopic disease, our technic of biopsy for obtaining tissue for microscopic study in the operating room or later, changes to meet the demands of accurate diagnosis and lessens the dangers of unnecessarily extensive operations for benign conditions, and incomplete removal for the malignant ones. It is distinctly less dangerous to perform a biopsy on a doubtful lesion with an interval of time between the biopsy and the operation indicated by the microscopic study, than to perform an incomplete removal of the malignant disease and then, later attempt the complete operation.

It is to be thoroughly understood that the evidence in favor of a biopsy with an interval of time before the indicated operation is not based upon the difficulty of interpreting frozen sections of fresh material in the operating room, but upon the fact that many, perhaps the majority, of pathologists responsible for the diagnosis in the operating room, are often in doubt in these very early cases, and the object of biopsy with an interval of

time is to give them an opportunity to submit the permanent sections to pathological colleagues, and thus reduce the chances of mistakes.

SKIN

From birth to old age every physician will be called upon more frequently by his patients to decide whether a congenital or acquired small skin defect should be left alone, receive simple treatment, or be removed or irradiated. Some knowledge of the possible pathology of these skin lesions will be very helpful to every doctor, whether general practitioner or specialist. The most dangerous skin lesions are pigmented moles, elevated and in areas exposed to irritation. The least dangerous are fibromas or angiomas. No unhealed wound of the skin should be left alone. If it does not heal within a reasonable time, it should be referred to a specialist. Any lesion of the skin, including the nipple, which is scaly, or weeps, should at once receive a simple treatment—it should be washed with soap and hot water using absorbent cotton, then with alcohol, then covered with a little vaseline or a little one per cent yellow oxide of mercury, and then with a bit of cotton fixed with collodion, or a small piece of gauze held in place by adhesive straps.

In the majority of instances, when the skin defect is small, no matter what its character, the best treatment is complete excision with a good margin of normal skin. In most cases this is best done with a sharp knife, in others with the electric needle, in still others with coagulation or the electric cautery. The advantages of the knife are—in small lesions the scar is no more of a defect, but most important of all, lesions excised with a knife can be immediately submitted to frozen section, revealing at once not only the pathological type, but whether sufficient margin has been given the tumor area, irrespective of whether it is benign or malignant. It will be a very valuable adjunct to our endeavor to make cancer of the skin a preventable disease, to have every doctor know something about the pathology of the various types of skin defects, which may or may not develop into cancer.

ORAL CAVITY

I have already discussed this problem before the dentists Wednesday evening September 9th. It is not only in the fully developed cancer of the mouth or the distinctly evident benign or malignant tumor in the region of the teeth and jaws, that we feel that every doctor should know something about its pathology. This knowledge will not help his patients. We want every doctor to know something about the pathology of the lesions in the oral cavity which may precede and lead to cancer. The profession must cooperate and consult with the dentists in all troubles in the mucous membrane of the mouth and in the region of the teeth and the jaws. Any defect of any kind in the mucous membrane lining of the mouth in a man or woman who uses tobacco in any form, should never be neglected by a dentist or physician. The area may be the first sign of the chronic irritation of tobacco plus ragged, dirty teeth, ill-fitting plates or faulty bridge work. Treatment must be prompt, because malignancy may be imminent. The patient must be influenced to discontinue the use of tobacco in all forms and have his dentist clean and smooth the teeth, repair the bridge work or change the ill-fitting plates. When this happens there will be no cancer of the mouth. Long years of clinical and pathological studies have proved this, and every doctor must listen to this evidence, and a little knowledge of this pathology will make him a better practitioner of preventive medicine. Every doctor should also know that localized pain in tooth or jaw, a loose tooth, a gum boil, or a slight swelling in the region of the upper or lower jaw may be the first sign of malignancy, or of some condition that may precede it, and he should know enough about the pathology of the various lesions that may produce these symptoms, so he will know what to do when these patients seek his advice in the period most favorable for a cure. He will know the importance of preliminary x-ray plates and films of the teeth and jaws; of a complete diagnostic study before operative intervention, and of the tremendous protective importance of preparing, or at least suggesting, frozen sections during the

operation, or a biopsy with an interval of time before the radical procedure follows.

THE STOMACH

Every doctor should know that when the x-ray shows a filling defect on the gastric side of the pylorus, cancer cannot be excluded, except in very young indviduals. In such cases it is wiser to explore the stomach. When the filling defect is on the duodenal side of the pylorus, cancer is very rare, and when present is probably incurable. Therefore, for lesions in the region of the duodenum as shown by the x-ray, medical treatment is the one of choice, unless there is obstruction, hemorrhage, which does not react to treatment, or signs of perforation. Frequently, when the x-ray shows a definite filling defect on the gastric side of the pylorus, and, on opening the abdomen, one sees and feels the palpable mass in the wall of the stomach, it may be necessary to take a frozen section from the involved wall of the stomach, or a nodule from the omentum if present, to differentiate the benign from the malignant. In addition, every doctor should know that the surgeon who understands the pathology of gastric carcinoma will be the operator best adapted for resection of the stomach, because the less margin your pathological knowledge allows you to give the palpable cancer, the greater the chances that the least dangerous operation for restoring the continuity of the duodenum and the remainder of the stomach will be possible.

When every doctor knows more about the pathology of ulcer, papilloma and cancer of the stomach, and ulcer of the duodenum, I am confident that more patients will receive a gastro-intestinal x-ray and laboratory examination in time for the recognition and subsequent resection of a cancer of the stomach in its curable stage, and in the recognition of ulcer of the duodenum when medical treatment offers the best immediate and permanent cure. Today the percentage of inoperable cancer of the stomach is far too great as well as the later and complicated stages of duodenal ulcer.

THE COLON

The majority of doctors do not know the good prognosis after resection for cancer of the colon in its early stages. A piece of the colon can be resected and the two ends sutured, either end-to-end, or laterally, or end-to-side, and the operation is not a dangerous one. We do not know whether every cancer of the colon begins in a preexisting benign lesion, such as a papilloma, but we do know that with rare exceptions every patient whose record we have and was found to be suffering with cancer of the colon, was aware of definite symptoms months or years before obstruction, and, unfortunately, months or years before his symptoms prompted his doctor to an x-ray and proctoscopic examination. As I have already stated, the greatest factor which leads members of the medical profession to delay special examinations, is their lack of knowledge of the pathology of the part, especially in relation to the possibility of malignancy. Studies show that intestinal obstruction brought the first cases of cancer of the colon to surgery and not the symptoms that preceded the obstruction. As in the stomach, so in the colon, the operator's knowledge of the pathology of cancer allows him to respect the malignant area with the least margin permissible. In many instances this makes the approximation of the two ends a simpler and less dangerous procedure.

THE RECTUM

Of all cancers of the gastro-intestinal tract, cancer of the rectum came under observation of operating surgeons in an operable stage long before cancer of the colon or stomach. Kraske's operation for complete resection of the rectum was well established when I came to Halsted's clinic in 1892. I am confident that if the medical profession knew less about the pathology of hemorrhoids, fistula and fissure of the rectum, and more about polypoid tumors and cancer, there would have been many more cures of cancer of the rectum before 1900 and even today. No diagnostic survey is complete without the examination of the rectum with the finger and the proctoscope, and I am beginning to feel that when the urologist examines the prostate with his finger in the rectum, he should take that opportunity to

further protect his patient by an investigation of the rectum with the proctoscope.

CONCLUSION

It is unnecessary in this short paper to give any further examples. I am trying to impress upon myself and every doctor who hears or reads this paper, that pathology is still a fundamental part of medicine, whether you are in general or special practice. How much pathology you should know depends upon your practice, but every doctor who practices medicine and is therefore responsible for the lives of his patients should know enough pathology to allow him to make the best of his opportunities to protect his patients from the late stages of cancer, and, to steer, if possible, his patients towards the recognition of their local troubles before or in the early stage of, cancer. In addition, I am anxious that every doctor should know that cancer and precancerous lesions and benign lesions that may simulate one or both, are becoming microscopic diseases; that the necessity for frozen sections in the operating room is increasing; that the character of biopsy and its technique are changing. All of this has been brought about through the education of the people by the medical profession.

Encouragements in the Surgical Treatment of Carcinoma of the Colon and Rectum*

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When the diagnosis of carcinoma of the large bowel or rectum is made, almost universally an air of pessimism pervades the situation and both the patient and the examining physician feel a sense of helplessness, or even hopelessness, which is entirely unwarranted if one, in a more optimistic vein, searches for favorable features in the situation. There are a number of outstanding facts, no longer unsubstantiated, which should encourage sufferers with carcinoma and members of the medical profession in regard to malignancy of the large bowel and rectum. These may be grouped under the following headings: (1) favorable prognosis; (2) the probable fact, with a bit of conjecture, to be sure, that the etiology of carcinoma of these organs is less baffling than formerly, since the relationship of multiple polyps of the large bowel and rectum to malignancy is being evaluated more accurately; (3) the markedly increased diagnostic acumen with which these lesions are now demonstrated by the roentgen rays and the protoscope; (4) the high plane of technical perfection to which operative maneuvers on the large bowel and rectum have been lifted within the past decade, and (5) the lowered mortality rate and more satisfactory end-results which are the result of the foregoing factors.

FAVORABLE PROGNOSIS

For a long time it has been readily recognized that carcinoma of the large bowel and rectum carries a favorable prognosis if the growth is radically extirpated in a stage of its development when distant metastasis has not taken place. The importance of this is easily recognized when one remembers that 10 per cent of the carcinomas occurring in the gastro-intestinal tract are found in the large bowel and rectum. Their tendency to remain local for a long time, without invading even the glands in immediate juxtaposition to the growth, the tendency of the majority of the growths to be of an average or low grade of malignancy, and the favorable results attending radical extirpation of either the large bowel or rectum, should encourage a feeling of optimism and stimulate further progress in combating malignancy in this situation.

THE PART PLAYED BY POLYPS IN THE PRODUCTION OF MALIGNANCY IN THE COLON AND RECTUM

Surmises as to etiologic factors involved in the production of carcinoma are, perhaps,

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frequently unwise or ill-timed, but there is little question that one is able to trace certain lesions, frequently found in the rectum and large bowel, through the different stages of their metamorphosis into malignant growths. I refer particularly to the changes which one sees in the polyps, multiple or single, which are so frequently found in an otherwise normal colon. That these polyps do undergo certain changes which result in full-grown adenocarcinoma of the rectum or colon, is no longer debatable. In conjunction with FitzGibbon, I have reported thirteen cases from The Mayo Clinic, in which these changes are definitely demonstrated. The classification of these polyps was dissimilar to that which is commonly employed in articles in which the proposed etiologic factors producing the polyps, or clinical manifestations of the same, have been taken into consideration. Our classification was based on purely histologic structural changes and paralleled the work of Hauser, Wechselmann, Schmieden, Westhaus and others, in establishing certain criteria which strengthened the evidence that these small, pedunculated tumefactions, that apparently for a long time remain innocent, and so frequently are found in this organ, are, in reality, in certain instances, and perhaps oftener than one is inclined to think, precancerous lesions. In our classification, which did not include any of the inflammatory types of polyps secondary to chronic ulcerative colitis, tuberculosis, or other such lesions, the polyps were divided into three groups, which depend for their differences on the changes in the structural elements, both epithelial and connective tissue.

In the polyps of group 1, the epithelial elements are practically normal, and the tumefactions are small, rough nodules seen on the mucous membrane of the bowel, varying in size from a pin-point to a mass 1 or 2 cm. in diameter on cross section. The very striking frequency of occurrence of this type of polyp in colons examined in the mortuary, leads one to wonder at the approximate normal incidence of this type of tumor in the large bowel in otherwise normal persons. It is conceivable but highly improbable that they may become cancerous but I strongly question whether there is much evidence to support such a view.

The polyps of group 2 are easily distinguishable from those of group 1 by reason of their structural changes, and I believe that those of group 2 are direct precursors of definite malignant changes. The epithelium in this group fails to differentiate into normal mucosa, the cells are elongated and line the tubules in a single layer, or may be compressed together laterally and project into the adjacent connective tissue or into the lumen of the tubule. There is a change in the underlying connective tissue, which, because of the tug of the peristalsis of the bowel, begins to be pulled into the polyp and thus forms a stalk. The rapidity of growth of these polyps is unquestionably in direct proportion to this activity. The polyps become large, polypoid, pedunculated masses which project into the lumen of the bowel, and for this very reason are more favorable of prognosis than polyps of group 3, which are in a more advanced stage and are represented by completely undifferentiated epithelium, which outpaces the connective tissue to such an extent that there is no pedicle, but the resulting malignant metamorphosis produces a deep-seated, infiltrating type of carcinoma, frequently small, always sessile, penetrating, and growing toward the peritoneal coat of the bowel rather than toward its intraluminary portion. For this reason, as well as on account of the activity of the growth, carcinomas which develop from this group of polyps are of less favorable prognosis, because of the likelihood of rapid lymphatic involvement and consequent distant metastatic deposit.

To support further the idea that polyps develop into carcinoma, one has only to consider the multiple adenomas of the colon, the congenital type of which is a well recognized pathologic lesion. This clinical picture, which is far from unique, presents a colon which is studded with polyps, from rectum to ileocecal valve, in some instances leaving only a small amount of normal mucous membrane between the little tumefactions. This type of lesion, similar to that in the stomach, described by Menetrier as "polyadenome en nappe," and called by other authors "adeno-

matosis" or "multiple polyposis," has a familial tendency and is well known to undergo malignant metamorphosis in about 50 per cent of the cases. Recently I reported three such cases, in which total colectomy had been done successfully at The Mayo Clinic in the last three years, and in the specimens of which were demonstrated multiple adenocarcinoma in the presence of, and developing on the basis of polyps.

The intriguing theory that all carcinomas of the colon develop on the basis of polyps is one that I am not prepared to defend without some reservation, but I strongly suspect that a great many of these malignant tumors do develop in just this manner, and without knowing the initiating force which stimulates hyperplasia of certain elements of the intestinal wall into an activity which by its advance becomes malignant, I would not hesitate to commit myself to the conclusion that a great many of the carcinomas in this region, perhaps more than we suspect, are thus etiologically explainable. The obvious corollary is that polyps of any size in the rectum and sigmoid, discoverable by proctoscopic examination and removable in the same way, should be extirpated just as commonly as precancerous lesion in any other portion of the body.

DIAGNOSIS

Although the diagnosis of malignant lesions of the large bowel and their differential diagnosis from benign conditions has been immeasurably forwarded by roentgenologic development, a careful anamnesis and physical examination still remains the most valuable method available of interpretation of pathologic changes. Unfortunately, there are no pathognomonic signs of carcinoma of the large bowel, common to all of these lesions, which occur in their incipient stages. Perhaps irregularity of intestinal habit is the most constant sign associated with the majority of these lesions, and second to this, the appearance of blood or obstructive phenomena must rank in importance. Any description of symptoms of malignant lesions of the large bowel must take into consideration certain modifying factors, such as situation of the growth and its pathologic type and duration, which will be of greatest assistance in localization and interpretation.

The large bowel should be considered as two distinct halves, a right half which is the absorptive half, and a left half which is a storehouse. The lesions of the right half of the colon cause physiologic disturbances, modified in their symptoms, first, by the liquid content of the segment; second, by a distinctive pathologic type of growth, such as large, flat, ulcerating, and in the majority of instances, not obstructive lesions, and third, the anatomic consideration of the size of the bowel, which differs from its fellow of the opposite side by the thinness of its musculature and hugely increased diameter. There are three distinct clinical groups of carcinoma of the right half of the colon which may be commonly designated (1) the dyspeptic group; (2) the anemic group, and (3) the silent group. Patients of the dyspeptic group commonly have symptoms referable to the ileocecal coil, such as one frequently encounters in chronic appendicitis, but not infrequently they may be referable to the upper portion of the abdomen, and may be confused with cholecystic disease or duodenal lesions until the roentgenogram rules these out. Patients of the anemic group present themselves frequently without premonitory symptoms other than those of weakness, and without visible loss of blood. It is not uncommon, in this type of case, to find the patient unable to carry on his work without his knowing a good reason for his disability, and suddenly, on examination, to be discovered to be profoundly anemic, so anemic in fact that primary blood dyscrasia is often suspected. The silent group comprises about 10 per cent of the cases of carcinoma of the colon, and, as is readily seen, when accidentally discovered is a most favorable type for radical extirpation.

In the left half of the colon, the obstructive phenomena dominate the clinical picture and there are good reasons for this: the pathologic growths are of the encircling, signet-ring type, more often than not, and the fecal content is hard and formed, and with difficulty can be forced through a stenotic segment. The amount of obstruction influences the symptoms as they manifest

themselves. In a small group, acute intestinal obstruction, hitherto unsuspected, comes on without premonitory warning. The majority of patients, however, depend on the slow stenosis of the segment for symptoms and go through the various grades from chronic to subacute obstruction, depending on the time at which they present themselves for investigation. Symptoms such as borborygmus, visible peristalsis, nausea and vomiting, and tenesmus, usually occur late, and by the time they are well developed the carcinoma is far advanced.

Confirmation of a suspected colonic lesion is now possible by the accurate roentgenologic technic that is in common use. The accuracy of the roentgenologic examination is in direct proportion to the skill of the roentgenologist, and today is as satisfactory as the diagnosis of gastric and duodenal lesions was formerly. At The Mayo Clinic, in 1929, error in roentgenologic diagnosis was made in only three cases of 102 of carcinoma of the large bowel distal to the lower third of the sigmoid. A filling defect, or visualization of interference with the integrity of the lumen of the bowel, is so pronounced in the majority of instances in which accurate preparation has been made that experience with the fluoroscope promises to continue this accuracy. The barium clysma, roentgenologically controlled, aided by palpatory manipulation, and by verification of the results by roentgenography, is the method of choice for accurate localization of the filling defect and for precise determination of its pathognomonic characteristics.

To epitomize the symptoms of colonic carcinoma: the most important early evidences of carcinoma of any portion of the large bowel are changes in intestinal habit, as evidenced by irritability, mucous diarrhea, or alternating periods of diarrhea and constipation; localized pain or tenderness, without a tendency to disappear, tumefaction and profound anemia not accompanied by loss of blood, or, if the lesion is in the left side of the colon beyond the middle of the transverse segment, some type of obstruction. If, in the presence of these suggestive phenomena, a complete gastro-intestinal examination at the hands of an experienced roentgenologist is undertaken, one may feel great confidence in the accurate localization and interpretation of the lesion. It would be a decided advantage and would influence materially, in the right direction, the progress in the early diagnosis of colonic lesions if a satisfactory and accurate roentgenoscopic examination of the large bowel could be added to routine physical examinations.

Carcinoma of the rectum, on the other hand, is not diagnosed by the use of roentgen rays. As a matter of fact, the value of roentgen rays in the diagnosis of gastro-intestinal lesions does not extend distal to the juncture of the middle and lower portions of the sigmoid. Beyond this point, the diagnosis of malignancy, or its exclusion, invariably should be made by digital examination or proctoscopic inspection, or both. All carcinomas of the rectum and rectosigmoid are recognizable and should be diagnosed if a satisfactory examination of this type is carried out. The symptoms of carcinoma of the rectum and lower portion of the sigmoid usually are confused with the symptoms of hemorrhoids, for the reason that blood in the stool or on the stool is perhaps the most prominent symptom, second only to change in bowel habit. Suffice it to say, that blood in the stool or on the stool, should always be considered as coming from a carcinoma until the reverse opinion is established. Perhaps, as frequently as not, blood in the stool or on the stool will be from hemorrhoids instead of carcinoma, but so much valuable time is lost, and so many operable conditions become inoperable because of delay in establishing the fact that one invariably should consider a bloody discharge from the rectum as indicative of a malignant lesion until one is sure that the cause is benign. Constipation is a symptom of little value in the history of carcinoma of the rectum, for the obvious reason that the multiple proprietary preparations advocated for all lesions of the bowel are aimed in a large measure at constipation and are so readily available to all patients, that, with danger to the patient's life, the complaint is rapidly decreasing in incidence. Constipation which is actually due to obstruction of the lumen is usually a symptom of rectosigmoid carcinoma but not a symp-

tom of ampullary carcinoma. Tenesmus, likewise, is a symptom of carcinoma of the rectum as it approaches the sphincteric muscle. There is little if any tenesmus present when the growth is at the rectosigmoid or high in the rectum. Loss of weight, cachexia, dehydration, and pencil-like stools are usually valueless as symptoms. If they are the result of rectal carcinoma they indicate a lesion that is far advanced, in which one should perhaps consider metastasis as already present. If, however, with the readily accessible lesion, easily demonstrated by digital examination, or at least by proctoscopy, one would invariably examine the rectum when patients present themselves complaining of symptoms referable to the rectum or bowel, the 15 per cent of patients who come to operation for carcinoma of the rectum, after having had their hemorrhoids recently removed, would be eliminated. Recently I have made it a practice to obtain biopsy by means of a cutting cautery, of all carcinomas of the rectum, not so much to establish the diagnosis, because the characteristic appearance of the lesion always is sufficient for that, but with the idea of establishing the grade of malignancy as an aid in prognosis and also to assist in determining whether operation should be undertaken or radium used as the most satisfactory type of treatment.

OPERATIVE MANEUVERS

Once the diagnosis of carcinoma of the colon or rectum is established, save in the extreme instances of acute intestinal obstruction, emergency measures are not necessary for its relief. Adequate preoperative preparation, which consists of rehabilitation of the patient's general resistance and decompression of the colon, has enhanced the end-results following surgical extirpation of these lesions. By segregating this group of patients in a small unit, under individual control, and by adoption of a number of preliminary steps, as well as well planned operative maneuvers, the factors of safety which I have found most important are: (1) adequate preoperative rehabilitation; (2) selection of the optimal time for operation; (3) individualization of each patient, with selection of an indicated operation rather than a standard one; (4) use of intraperitoneal vaccination with colon bacillus and streptococci; (5) employment, in a large number of cases, of operation in multiple stages; (6) selection of satisfactory anesthesia for each case rather than acceptance of one anesthetic as a standard, and (7) rigid adherence to a standardized postoperative regimen.

Several factors influence the choice of operation in the two halves of the colon. As a general rule, one may accept graded procedures in these cases as the operations of choice. In the right half of the colon it has been my belief that an operation in two stages, consisting of aseptic ileocolostomy involving the terminal part of the ileum and the middle of the transverse colon, followed by subsequent resection of the right half of the colon around to the anastomosis, has been the most satisfactory procedure. I believe the employment of end-to-side anastomosis, rather than anastomosis of the lateral type, has been most advantageous, since the graded operation in the right half of the colon is performed with the idea of reducing as much as possible the amount of infection around the local growth. By completely severing the small bowel, turning in the cecal end, and implanting the proximal end in the colon, one sidetracks all of the content of the small bowel, and with the exception of the colonic content, which is thrown against the growth by reverse peristalsis, completely prevents any intestinal content passing over the ulcerative carcinomatous surface.

Occasionally one may find it desirable to do an operation in one stage for lesions of the right half of the colon, but, as a rule, it has seemed satisfactory to abandon this procedure. In the event that an operation in one stage is chosen, decompression by a Witzel type of enterostomy, involving the ileum, is most satisfactory. In operations on the left half of the colon it is imperative that decompression be adequate and satisfactory before any type of procedure is undertaken. If, by preliminary administration of enemas, and judicious purgation extending over a period of five days to a week, one is able to decompress the colon and relieve the obstruction, I believe a resection in one stage, by an

obstructive method which I have described elsewhere, is the operation of choice. Failing this, I think decompression by cecostomy or colostomy should always be made, with the idea of doing resection and anastomosis later. Never to attempt primary suture anastomosis in the left half of the colon, without decompression prior to or at the time of operation, is a rule from which I have not deviated in a considerable time.

MORTALITY AND OPERABILITY

Mortality statistics of any surgical procedure should desirably be revised downward. This is true of the immediate mortality in surgery of the colon and rectum in the last ten years, and a comparative study of mortality from carcinoma of these organs is entirely favorable when placed beside that of carcinoma of the remainder of the alimentary canal. There are few organic lesions of the large bowel other than malignant lesions which necessitate surgical attack, but, unfortunately, most of them are of a complicated nature. Because of infection in and around the growths, the uncertainty of the blood supply and the technical difficulties of operation, the deaths in hospital following this type of operation have rarely been reduced to less than 10 per cent. The end-results, however, following successful extirpation of colonic and rectal growths, are not only comparable but superior to the ultimate end-results of operation on the remainder of the gastro-intestinal tract. One should keep in mind that to decrease the mortality rate beyond a certain figure denies surgical help to many patients who might otherwise be cured. If one accepts this high rate, and thereby attacks borderline cases, one will be rewarded by a larger percentage of living patients in any given hundred cases at the end of a period of three to five years than if a closer selection from the standpoint of operability had been adhered to. After all, operability is an individual problem which each surgeon must decide for himself. What is resectable with a relatively satisfactory operative mortality in the hands of one surgeon may not be resectable without prohibitive mortality in the hands of another. And yet, to refuse resection to individuals who have not demonstrable hepatic metastasis, one must be convinced of the total immobility of the local growth, of attachment to vital viscera, sacrifice of which is unwise, or that the patient's general condition renders him totally unable to withstand any formidable procedure.

The operability rate in The Mayo Clinic in the last two years has been approximately 57 per cent; a satisfactory one from many standpoints. The mortality statistics of operation on the two halves of the colon have differed somewhat. For numerous reasons, the first segment of the colon, that is, the terminal part of the ileum, the cecum, ascending colon, hepatic flexure, and transverse colon around to its middle, has borne a slightly higher mortality rate than its fellow of the opposite side. Two years ago, in making a yearly report of the colonic service, I found we had performed 160 operations in this segment with fourteen deaths, a mortality rate of 8.7 per cent, whereas, in the left half of the colon, down to the rectosigmoid, there had been 227 operations with seventeen deaths, a mortality rate of 7.4 per cent. These slight differences are unimportant, and unquestionably will vary from year to year, but they indicate the tendency to revise downward the mortality figures without sacrificing satisfactory operability. To increase the horizon of operability, then, by making use of the improvement in diagnostic methods, particularly those of roentgenology and proctoscopy, permitting earlier recognition of the lesions of the large bowel and rectum, and at the same time emphasizing the importance of routine examination following any symptoms of intestinal upset or change of intestinal habit, should bring about an increase in the operable group of malignant growths in this situation, with a resulting increase in satisfactory end-results following their successful extirpation.

POOR RELIEF LAWS IN SECOND EDITION

Exhausting the first edition of 3,000 copies, a second edition of the Summary of Poor Relief Laws Affecting Care of the Indigent Sick was necessary to supply the demand from public relief officials. This summary, effective in all counties except Milwaukee, contains a digest of laws, rulings and practices and is available without charge.

The Differential Diagnosis of Ulcerative Lesions of the Large Intestine and Rectum with Special Reference to Proctoscopic Examination

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The most common diseases which produce ulceration of either the large intestine or rectum, or both, are: chronic ulcerative colitis, parasitic disease, the most common of which is amebic colitis, tuberculous colitis, diverticulitis and carcinoma. One of the most important and yet too little employed guides in the diagnosis of these diseases is proctoscopy. The clinical history and various laboratory tests such as roentgenoscopy and careful gross and microscopic examinations of the stools and rectal discharges are very valuable aids in arriving at a correct diagnosis, but not infrequently, the burden of proof rests upon the characteristic and unmistakable picture of the lesion as disclosed by the proctoscope.

CHRONIC BACTERIAL ULCERATIVE COLITIS

Chronic bacterial ulcerative colitis has its site of inception in the rectum and spreads toward the proximal portion of the colon, gradually involving the entire large bowel and often the terminal ileum. This mode of invasion occasionally results in a regional or migratory type of involvement. The selectivity of the disease for certain portions of the large intestine is relatively uncommon, but recently Bargen and Weber reported a series of 23 cases of localized or segmental ulcerative colitis. The clinical signs and symptoms of this infection are characterized by a history of recurrent and intermittent attacks of bloody, purulent, and mucoid rectal discharges mixed with feces of variable consistency and amount depending upon the severity of the disease and the extent of bowel involvement. Hence, if there is only involvement of the rectum and rectosigmoid, the stools may be scybalous with the patient constipated but yet having ten or more bloody, purulent, rectal emissions daily. Early in the course of the infection, these discharges are accompanied by great desire to strain, together with griping pain and tenesmus. As the ulcerations extend upward into the colon, the stools become liquid or mushy and are mixed with bloody pus and mucus. At this stage of the disease, the pain may be terrific, and gruelling abdominal cramps are not infrequent. However, it is not unusual for the patient to complain only of various indefinite sensations such as gas distention or griping along the course of the colon. Slight elevation of temperature is common in the chronic cases, but in the severe fulminating type, a septic fever occurs and there is a moderate leucocytosis with a predominance of the polymorphonuclear leucocytes. Fortunately, acute fulminating ulcerative colitis is not common, although when it does occur, the toxemia is profound and the tenderness on palpation along the course of the colon is marked. If a patient with chronic ulcerative colitis does not receive proper treatment soon after the onset of the infection, he may go on to progressive emaciation with secondary anemia due to the toxemia and the long continued blood-loss, and eventually to chronic invalidism.

Gross examination of the rectal discharge reveals a preponderance of pus mixed or streaked with mucus in varying amounts and blood which may be present either in the form of clots or as a bloody liquid. Under the microscope, various forms of streptococci in conjunction with large numbers of polymorphonuclear leucocytes are demonstrated.

The roentgenological findings of a well developed and clear-cut case of chronic ulcerative colitis, showing a fore-shortened, narrowed, non-haustrated colon with a definite lack of redundancy are not only characteristic and pathognomonic, but also yield a valuable clue as to the extent of the invasion proximal to the rectum, the severity of the disease, and the presence or absence of complications. When the disease is confined to the rectum, the roentgenological signs are neither as significant nor as trustworthy as when a large portion of the colon is involved. An accurate radiographic outline of the rectal mucosa is impractical because the anatomical location of the rectum deep in the

bony pelvis leaves it inaccessible to palpation; also there is too great a variation in the normal limits of size of the bulb-like rectal ampulla to demonstrate the typical foreshortening and narrowing. The roentgenological evidence in localized or segmental chronic ulcerative colitis is often confusing, especially in those cases where the involved segment is so shortened and the narrowing so abrupt that the filling defect produced may closely simulate carcinoma or even tuberculosis. In 11 of the 23 cases of segmental chronic ulcerative colitis which Bargen reported, the proctoscopic examination did not reveal any evidence of disease. These types of cases present real diagnostic difficulties and the therapeutic test with chronic ulcerative colitis serum is a distinct aid in clarifying the diagnosis.

The proctoscope not only plays a very important role in establishing the diagnosis of chronic ulcerative colitis, but also elicits the most positive data. Direct visualization by the proctoscope reveals the characteristic picture of a granular, easily bleeding and diffusely inflamed mucous membrane. The pathognomonic, wide-spread involvement, together with the unmistakable appearance of the lesion, renders the disease distinct from any other form of ulceration of the colon. There are myriads of minute ulcers usually not larger than one millimeter in diameter in all stages of development. Interspersed with these ulcers are seen areas of hyperemia and edema which later become miliary abscesses and ulcerate. From their base can be isolated the specific, causative organism, the diplostreptococcus of Bargen. In addition, there are often larger ulcers present due, in all probability, to either a confluence of the tiny miliary ulcers or a pressure necrosis, or both. These secondary ulcers are characterized by an irregular margin without any appreciable undermining and a shallow base covered by a tenacious membrane which does not heap up. The uniform, tubular contraction of the bowel lumen which is present in a well established case of chronic ulcerative colitis, is a result of the extensive involvement which includes the entire bowel wall.

In the long-standing infections, the proctoscope may disclose an associated polyposis. Bargen and Comfort, in reviewing over 600 cases of chronic ulcerative colitis, found that multiple polyposis eventually develops in approximately 10% of all cases. It is thus apparent that this condition is one of the most frequent complications which may occur. In view of the tendency of intestinal polyps to undergo malignant degeneration, generalized polyposis presents a serious problem. The relationship of polyps to malignancy has recently been further emphasized by FitzGibbon, who, in a study of the polyps in 13 cases of polyposis, found 24 carcinomas. The site of origin of 22 of these 24 carcinomas was traced back through an unbroken line to polyps, and he therefore concluded that "the histogenesis of carcinoma of the colon is mediated through the precancerous formation of polyps."

Fischer's advocated insufflation of the colon with air following evacuation of the bulk of barium has greatly enhanced the roentgenologist's ability to note the presence of polypoid growths. Furthermore, this improved radiologic technique, which was modified by Weber, has made it possible to determine more accurately the extent of polypoid dissemination in the colon. The individual polyps are seen as soft, rounded protrusions into the bowel lumen.

The diagnosis of polyposis can be made most satisfactorily by proctoscopic examination. Often the pedunculated lesions are seen in all stages of development and in varying sizes. Their finger-like tips may be mildly injected or even show slight mucosal ulceration depending to a certain extent upon the activity and the severity of the associated ulcerative colitis.

AMEBIC COLITIS

In the north temperate zone, amebic colitis is the most prevalent parasitic infection of the large bowel. As a rule, the clinical history does not present anything noteworthy that will help differentiate this disease from chronic ulcerative colitis or any other type of intestinal ulceration. The diarrhea, which may or may not be bloody, is usually severe and there is a tendency toward recurrent attacks with periods of complete remission. The stools are apt to be more frequent in the day time than at night, while in

chronic ulcerative colitis the day and night frequency remain about equal.

Examination of the loose, watery stools may, if the disease is advanced to an active ulcerative stage, reveal to the naked eye much mucus and fresh blood. Microscopic examination yields undoubtedly the most valuable diagnostic information. The finding of large numbers of endameba histolytica in the stools and rectal discharges usually clinches the diagnosis. However, it must be borne in mind that 5% of the patients with chronic ulcerative colitis are carriers of ameba. There is also a small percentage of patients in whom the parasite cannot be demonstrated in the rectal emissions. In such cases, scrapings obtained from the base of a fresh ulcer by means of a proctoscope may reveal the parasite.

The roentgenogram, except in the more severe or extensive cases, is not typical. Although the shadow at times resembles very closely that produced by chronic ulcerative colitis, the characteristic involvement is frequently in the right colon.

The proctoscopic picture, when positive, is pathognomonic and in many instances even when repeated stool tests have been negative, the proctoscopic evidence has established the diagnosis. Amebic ulcers are notoriously discrete and are frequently situated on the prominent folds of the bowel or involve the valves of Houston. The mucosa between the ulcers is fairly normal and is relatively uninvolved. Each ulcer appears punched out, is surrounded by a zone of hyperemia, and is sometimes covered by a greyish white material known as the "white cap". Amebic ulcers are seldom smaller than 2 millimeters in diameter and rarely coalesce except in severe cases. In the absence of typical proctoscopic findings, and the inability to demonstrate the endameba histolytica in the stools, the therapeutic tests with the administration of emetine hydrochloride hypodermically and arsenic by mouth in the form of stovarsol or treparsol can be used to a distinct advantage.

TUBERCULOUS COLITIS

Intestinal tuberculosis, both the ulcerative and the hyperplastic types, has its site of predilection in the ileocecal coil. Its association with pulmonary tuberculosis is a well-known fact. The symptoms of tuberculous colitis are vague, varied and rarely diagnostic even in well advanced cases. Progressive diarrhea, alternating with occasional periods of constipation is common early in the disease, but as the infection becomes more pronounced, the diarrhea becomes persistent and the stools, which seldom show gross blood, are thin and watery and the absence of pus is noticeable.

Careful microscopic examination of the stools reveals in most cases much epithelial debris, undigested food, and many tubercle bacilli. In view of the fact that other acid-fast organisms which have no pathogenicity such as bacillus smegma may have their habitat in the intestinal tract, the finding of acid-fast bacilli alone should not be considered diagnostic.

The roentgenogram of tuberculous colitis also simulates that of chronic ulcerative colitis, but the less marked obliteration of the haustra, together with the greater predominancy of tuberculosis in the ileo-cecal coil helps differentiate it. As the disease extends caudally from the ileocecal coil, there may be observed a definite, funnel-like deformity with a shadow presenting a very irregular edge.

Because of the localization of the disease in the intestinal tract, it is readily apparent that the proctoscope does not play as important a diagnostic role as in amebic colitis or chronic bacterial ulcerative colitis. When the lesions are observed through the proctoscope, the picture described is usually characteristic. The ulcers are large, irregular, shaggy, and deep with undermined, indurated margins; between these ulcers are areas of normal mucous membrane. Yeomans has called attention to the fact that the lesions encircle the bowel following the course of the blood vessels. This might easily account for the similarity of the filling defect as detected by roentgen rays in certain malignant and tuberculous lesions.

CONDITIONS MISTAKENLY CALLED COLITIS

There are various conditions mistakenly called colitis, the most common of which

comes under the heading of the so-called "mucous colitis". As a differential point, it seems advisable to briefly discuss this disorder. The etymology of the word colitis refers to an inflammatory disease of the colon and when this term is applied solely to infections and inflammatory lesions of the large bowel, much mental anguish and physical suffering will be alleviated. The term "mucous colitis" has been used of late years rather loosely and entirely too freely to designate various types of indeterminate abdominal distress which may or may not be associated with intestinal dysfunction. "Mucous colitis" should be looked upon and treated not as a primary intestinal disease, but as a part of a general body state. According to present knowledge, it is purely a form of colonic dysfunction which almost invariably has as its basis an underlying chronic nervous exhaustion or a hypersensitive nervous system.

It is characterized symptomatically by attacks of diarrhea which include either sharp, severe cramps in the middle or lower part of the abdomen or vague, uncomfortable sensations over the region of the descending and sigmoid colon. There may be a constipation instead of diarrhea, but this is the exception rather than the rule. When the diarrhea becomes severe, there is usually bloating, gas distention, and an increased amount of mucus appearing in the stools. It is not unusual for an emotional upset or dietary indiscretion to precipitate one of these episodes. Medicated enemas likewise have been known to induce these attacks and Tidy maintains that this type of treatment is occasionally responsible for the development of colitis in many otherwise healthy persons.

Examination of the loose, liquid stools reveals mucus in varying amounts either in the form of flecks or "strings", or as large tubular casts. The presence of abnormal amounts of this secretion in the stool does not necessarily indicate organic bowel disease. It is a well-established fact that the amount of mucus secreted will vary directly with the amount of intestinal irritation provided and with the sensitivity of the nervous mechanism involved.

The roentgenographic examination does not present any dependable group of signs. Spasm may occasionally be demonstrated, but it is not a predominating feature. The so-called "string sign" of Crane which is sometimes seen, is not pathognomonic evidence of colonic disturbance alone. The roentgenographic picture found in genuine colitis is entirely lacking in this condition.

Proctoscopic examination discloses a normal mucous membrane which may be very slightly hyperemic.

DIVERTICULITIS

Diverticulitis is essentially a disease of middle life and occurs almost entirely in persons who are sedentary and inclined to be corpulent. The outstanding and most constant symptom is pain, which is almost always situated in the lower left quadrant, due to the fact that the infection, with rare exceptions, is confined to the sigmoid. The pain which may not be typical in character is practically always present sometime during the course of the disease, and varies from intermittent sharp attacks to a fairly constant boring sensation. Constipation or alternate constipation and diarrhea occur more often than progressive diarrhea. In approximately 30% of the cases, it is possible to palpate a tender, well-marked tumefaction in the lower left quadrant. Bladder symptoms, which are fairly common, indicate either attachment to or perforation of the tumefection into the bladder and present a serious complication. A diagnosis of bladder fistula is easily made by means of the cystoscope.

The diagnosis of diverticulitis rests primarily upon roentgenological examination. The barium-filled diverticula are seen as rounded or oval shadows projecting from the intestinal lumen. These shadows associated with spasm or organic narrowing of the bowel are pathognomonic.

Examination with the proctoscope is not of much diagnostic value because the lesions are either too high to be reached with this instrument, or the angulation and deformity of the sigmoid precludes its use. However, proctoscopy is an aid in ruling out other conditions and if the lesion is extremely

low, direct visualization of the bowel lumen will corroborate the diagnosis.

CARCINOMA

It is generally accepted that approximately 10% of all carcinomas of the gastrointestinal tract, occur in the large bowel, and of this number, more than one half are at or below the rectosigmoid juncture. Rankin has emphasized the fact that practically all carcinomas of the large bowel and rectum reach the stage of ulceration or cause mild obstruction before suggestive symptoms appear. The early diagnosis of carcinoma leaves much to be desired. The clinical signs and symptoms of early neoplastic disease of the large bowel and rectum are of little diagnostic value, but are sufficiently alarming to warrant a careful and searching investigation. Inasmuch as the symptoms vary according to the involvement of the various segments of the bowel, it is practically impossible to enumerate accurately and in sequence a definite chain of symptoms, especially in the early cases. Any change in bowel habit demands a thorough investigation and must be considered the most significant symptomatic warning. Rectal bleeding, the blood being either mixed with the stool or simply streaking it, is the most constant sign of malignancy of the rectum and colon, and yet, only too often, this danger-signal is disregarded. This is perhaps due to the fact that hemorrhoids are frequently associated with rectal malignancy. In Rankin's series, 15% of the patients with rectal carcinoma had been operated on for hemorrhoids after the onset of symptoms.

The diagnosis of beginning malignancy rests almost entirely upon roentgenoscopy, proctoscopy, and digital examination. The roentgenological evidence in most cases is typical, and the filling defect produced is pathognomonic.

Almost all cases of carcinoma of the rectum can be diagnosed and localized by digital examination. Even when the growth is situated at the rectosigmoid juncture, the lesion occasionally prolapses or telescopes into the rectum and is felt by the examining finger. It is not unusual to obtain by digital examination a clear idea of the type, size, amount of fixation, and frequently the operability of the lesion.

In every case of suspected malignancy, proctoscopic examination should be performed in conjunction with and preferably before administration of the opaque enema. The reason for this procedure is obvious. The inaccesibility of the sigmoid colon deep in the bony pelvis, together with the frequent fixation there by any process affecting it or the presence of anomalous coils, will occasionally render the roentgenological diagnosis relatively uncertain. Likewise, there are those exceptionally rare cases of double carcinoma in which there may occur, not only a primary malignancy in the rectum or rectosigmoid, but also another entirely separate and distinct growth higher in the colonic flexure. It is self-evident that the interpretation of the roentgenological findings in these cases may be misleading, and unless proctoscopic examination is performed, the whole story may not be revealed.

A malignant ulcer is typical in appearance and should not be confused with any other form of bowel ulceration. Through the proctoscope, it is seen as a single, large, crater-like ulceration with a necrotic and bleeding base surrounded by an adjacent mucous membrane devoid of inflammatory changes. The edge of the ulcer is friable and ragged, but the encrouching tumor mass is firm and indurated. The diagnosis can be further substantiated by obtaining proctoscopically a small specimen of tissue for microscopic study.

COMMENT

It is a time-worn axiom that successful treatment and ultimate prognosis has as its basic principle the correct diagnosis of the disease. Notwithstanding the fact that the diagnosis cannot be established by anamnesis, all the above described diseases have definite, distinguishing, diagnostic characteristics which are unmistakable one from another. If every patient with intestinal dysfunction were subjected to a careful clinical, roentgenologic, and proctoscopic investigation, many serious disorders of the rectum or colon would be brought to the attention of

the physician during the time when the disorder is curable and often in its incipiency.

The diagnostic armamentarium can be greatly augmented by the use of the proctoscope. Proctoscopy frequently offers the sole key to the diagnosis, not only in early chronic ulcerative colitis when the rectum alone is affected, but also in certain cases of segmental chronic ulcerative colitis where the rectum or lower sigmoid are involved and the roentgenological signs which may closely resemble tuberculous colitis or even extensive malignant disease, are not clearly depicted.

The importance of proctoscopic examination must not be overlooked in amebic colitis, especially in those cases where either the stool tests are negative or misleading or the roentgenogram does not yield conclusive diagnostic information. The roentgenographic signs in well-advanced, amebic colitis are frequently indistinguishable from those observed in chronic ulcerative colitis. An added differential procedure that ranks with the use of ulcerative colitis serum in ulcerative colitis is the employment of specific drug therapy. This measure is of decided value in indeterminate and obscure cases.

Inasmuch as intestinal tuberculosis seldom manifests itself in the sigmoid or rectum, proctoscopic examination rarely reveals evidence of tuberculous colitis. The roentgen ray may be a helpful laboratory guide, but many times it is difficult roentgenoscopically to differentiate tuberculous colitis from other forms of intestinal ulceration. The presence of tuberculous foci elsewhere in the body, together with a positive roentgenogram and the finding of large numbers of tubercle bacilli in the stools and rectal discharges, generally establishes the diagnosis.

It is of utmost importance to remember that genuine colitis is an inflammatory disease of the colon and no condition should be diagnosed as such until thorough investigation shows that true inflammation actually exists.

The diagnosis of diverticulitis is made chiefly by radiographic examination. The proctoscopic examination is only of value in those few cases where the lesion is extremely low and the distal portion of the sigmoid can be visualized.

An accurate evaluation of the radiologic and proctoscopic findings, plus the rigid employment of the examining finger, is necessary to confirm the diagnosis of early malignancy of the large bowel or rectum. The filling defect detected under the flouroscope is typical and pathognomonic in an exceedingly large percentage of cases. In view of this fact, there is too often a tendency to lean, for diagnostic confirmation too heavily, and to the exclusion of the endoscope, upon the roentgen ray. The value of the proctoscope in determining the presence or absence of neoplastic growths in the rectum and lower third of the sigmoid cannot be over-emphasized when it is remembered that double carcinoma does occur and that the inaccessibility of the lower sigmoid to palpation, its frequent fixation deep in the pelvis, and the occasional multiplicity of its coils often precludes an accurate roentgenoscopic diagnosis.

Acute Appendicitis*

By JOSEPH DEAN, M. D.
Madison

Any disease that claims a mortality of 15 per 100,000 of our population yearly is worthy of recapitulation and study. It is rather humiliating to the medical profession to learn from a resume of statistics that our death rate today is higher than it was in 1909 and since that year has risen steadily in Wisconsin. In 1909 our death rate was 11.3 per 100,000 and at the end of 1929 had risen to 15.1 per 100,000. Perusal of the U. S. Public Health statistics gives practically the same figures. Sixteen thousand persons died in the U. S. in 1929 from acute appendicitis, a disease which is assumed to be thoroughly understood on the part of the

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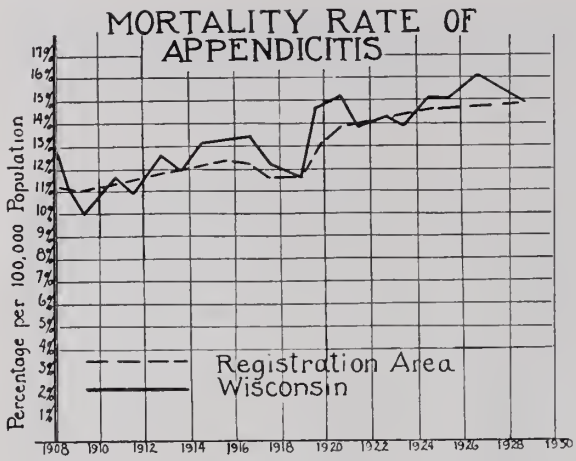

average practitioner. Our death rate is higher than that of England or Paris, the former having a ten-year average of 6.9 and Paris 6.7 per 100,000. The analysis of the death rates from acute appendicitis in 127 American cities as published by the Prudential Insurance Company shows very pointedly that there is an increasing mortality from this disease. The Metropolitan Insurance Company reports a steady upward trend since 1911 in the mortality rates of acute appendicitis.

Death rates from appendicitis per 100,000 population in Wisconsin and U. S. Registration Area 1908–1909:

Year	*Rate in Wisconsin*	*Rate in U. S. Registration Area*
1908	13.3	11.7
1909	11.3	11.3
1910	10.3	11.4
1911	11.6	11.6
1912	11.1	11.6
1913	12.6	12.1
1914	12.3	12.3
1915	13.3	12.5
1916	13.5	12.8
1917	13.7	12.4
1918	12.5	11.9
1919	11.9	11.8
1920	14.8	13.4
1921	15.2	14.1
1922	14.1	14.2
1923	14.6	14.8
1924	14.3	14.9
1925	15.3	15.1
1926	15.4	15.0
1927	16.3	15.0
1928	15.7	15.2
1929	15.1	15.2

In a four-year period ending December 31, 1930, we admitted and operated 592 cases of acute appendicitis at St. Mary's Hospital, Madison, Wisconsin. A check-up of these cases revealed the startling fact that 177 of these cases were perforated on admission and suffering from the many and various complications that can and do result from perforation. Twenty-three of the perforated cases died. Of the remaining non-perforated acute cases totalling 415, only 4 died, less than one in one hundred, two dying of pneumonia, one of uraemia and one of intestinal obstruction.

Twenty-three deaths from perforated appendicitis represent twenty-three tragedies. Who is to blame and what is the answer? Is it not a reflection upon the intelligence of the medical profession that we have stopped talking and writing upon this, the most frequent of abdominal disorders? Have we not relegated this subject to the shelf of mastered subjects and interested ourselves with other problems to the detriment of ourselves and patients? If so, our increasing death rate should disillusion us. Is our teaching of this subject on safe grounds and are we not relying too much on corroborative tests rather than upon the clinical history and physical signs of the patient?

One of the greatest crusaders for the early recognition of and operation for acute appendicitis was the late J. B. Murphy. In 1915 he made this statement: "The mortality in appendicitis is still too great. It is far beyond that which timely and efficient surgical treatment affords. The present laxity in treatment appears to be due to the fact that the subject is not receiving the forceful attention in the literature that it did ten or fifteen years ago." Were Murphy alive today he would still be preaching with all the fervor of his temperamental soul against procrastination and delay, for the yearly toll is greater now than in his day. That this disease is not receiving the attention it deserves and that we are not keeping pace with our treatment of this as compared with other diseases, needs no argument. Typhoid, smallpox, diphtheria and other similar infections and contagious diseases are showing a very rapid and positive decline both in numbers and death rate—thanks to the efficiency and vigilance of our Boards of Health.

Regional surgery, particularly that of the thyroid gland, lung, chest, genito-urinary,

prostate, stomach and gall bladder, all have shown and are still showing a decided decline in death rates. Why then not appendicitis? Who is to blame? We will admit that there are many factors entering into mortality rates over which the physician and surgeon have no control, particularly delay in seeking medical aid and the ever deadly laxative being two of the greatest factors. However, the medical profession plays the greatest part in the responsibility of treating this disease, and the profession as a whole is not meeting this responsibility cannot be disputed.

At the risk of boring you with this supposedly threadbare subject, let us cover the clinical history and symptoms of this disease. One symptom is always present and is always first:

Pain. Given 100 patients with acute appendicitis, 100 patients will have pain first and always. The pain may vary in its location but is always present first and we look with suspicion upon any and every case diagnosed as appendicitis whose first symptom is not pain. The pain may be diffuse in type and generalized in character. It may be in the flank, in the costo-vertebral angle, in the pelvis or in the epigastrium, but it is always the first symptom. We have been struck with the marked severity of epigastric pain in patients whose appendix is found in the pelvis. In patients whose appendix lies free in the peritoneal cavity, epigastric pain is the rule. In patients whose appendices have been buried in webs of peritoneal tissue or adherent intimately to the caecum, the initial pain is usually felt at the anatomical site of the appendix. The pain is usually sudden in onset and reaches its maximum intensity in four to six hours. When it ceases suddenly within the first thirty-six hours, it is due either to a rupture into the caecum, into the general peritoneal cavity, or to gangrene of the appendix. This cessation of pain is often erroneously interpreted, with an increase in danger to the patient. The pain may be referred to any portion of the abdomen, to the epigastrium, gall bladder region or rectum. Malposition of the caecum and ascending colon has been the cause of many a mistake in a case of acute appendicitis being diagnosed as gall stone colic or gall bladder disease. In a case recently seen and operated by us the patient's first symptom was an excruciating backache, the pain being localized over the right sacro-iliac joint. At operation a retrocaecal, perforated appendix with localized abscess was found. Severe pain after the primary subsidence is always a signal of great danger as it announces a beginning peritonitis from perforation.

Nausea and Vomiting follow the pain but are not always present and never precede the pain. Nausea occurs only in about 40% of cases and is often absent. Vomiting likewise is often absent, occurring only in about 50% of the non-perforated type; the incidence increasing, of course, when peritonitis occurs, becoming almost constant when general peritonitis exists and absorption increases.

Abdominal sensitiveness with tension and rigidity is a sign, that, next to the subjective symptom pain, is of greatest value in the diagnosis of acute appendicitis and yet this sign is absent in about 10% of all acute cases. The local tenderness varies with the location of the appendix and many times is entirely absent in the presence of gangrenous appendicitis. Abdominal sensitiveness and rigidity may be present, yet in most cases are absent when an acute appendix lies below the brim of the pelvis and in these cases failure to make a rectal or vaginal examination is the human element that often spells disaster. The local tenderness is at first diffuse, although rigidity is not necessarily present at first. After six or eight hours tenderness occurs in 90% of cases over the anatomical location of the appendix. If the sensitiveness is once localized and suddenly increases with secondary nausea and vomiting, it indicates a perforation with spreading infection.

Temperature is usually present, sometime within the first thirty-six hours, but is absent entirely in at least 20% of cases so that it is not an infallible guide. It is not uncommon to observe a gangrenous appendix without any febrile reaction, however, with the onset of complications or perforation, there is nearly always a rise in temperature. In the

early stages of the disease the absence of temperature in the presence of other signs and symptoms should not give us a false sense of security. In a word, a low temperature is the rule where no complications exist. Chills may be present during an acute appendicitis and suggest thrombosis.

Pulse. The character of the pulse is of little value. In children it is apt to be high. In adults the variations are of no value in the early stages. After perforation in about 65% of cases coupled with increase of pain and temperature it confirms complications.

Leucocytosis is confirmatory only and should be used only as helpful evidence. An increase in the white blood count is an index of the products of infection, but there are many cases of severe infection which cause gangrene and peritonitis where no leucocytosis is present because of a reduction in the defense mechanism. In the writer's opinion, too much importance is attached to the value of a white blood count and not enough to the clinical history and physical signs. It is not an uncommon experience to see patients with acute appendicitis, blood counted to perforation when all the symptoms and signs were typical and classical. An increase in the polymorphonuclears is of more value than the total count. In the influenza epidemic of 1918–1919 it was not uncommon to see acute suppurative appendicitis with a leucopenia. A blood picture is evidence that should always be sought but never used as a determining factor in one's judgment as to when or when not to operate. In our teaching of students altogether too much importance is attached to this evidence, that is, leucocytosis.

COMMENT

The above mentioned signs and symptoms are common knowledge to the medical profession, yet the mortality rates from this disease are increasing. Again the question, who is to blame and what is the answer? The medical profession can not escape just criticism and must shoulder the responsibility for a large number of deaths occurring yearly from acute appendicitis. Too much optimism toward this disease exists in the profession and is reflected in the attitude of the public, yet the yearly toll is increasing. Our optimism is not confirmed by facts. Who is to blame? We are, in the main, first by our indifference to this the most common of all abdominal surgical diseases, second by our failure to make an early diagnosis and third, by our procrastination in its proper treatment.

Intravenous Cholecystography; Technic and Analysis of 800 Cases

By L. V. LITTIG, M. D., and J. N. SISK, M. D.
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The purpose of this paper is fourfold: first, to present the results of 800 gall bladder examinations by the intravenous method; secondly, to compare the results of a series of non-functioning gall bladders examined by the oral method when checked intravenously; thirdly, to compare the frequency of gall bladder mal-function with the frequency of lesions found elsewhere in the gastro-intestinal tract, and fourthly, to respond to many requests made to both of us for the details of an intravenous technic for cholecystography.

Since the original work of Drs. Graham, Cole, Copher and Moore in 1923 there has been considerable in the literature about cholecystography. As this literature is abundant and readily available, we are making no reference to it.

Prior to September, 1929, we used the oral method of administering the dye for cholecystography. Very often excellent gall bladder shadows were obtained, but this was not the rule. In more than fifty per cent of cases, as shown in our statistics later, we were confronted with no shadow or with a faint indeterminate shadow. In many of these cases the dye appeared in the colon, showing that it had not been absorbed into the blood stream. From this observation and from the fact that the surgeons had removed a few normal gall bladders and explored others to find them normal, an uncertainty developed in our minds as to the value

of our no shadow and faint shadow reports by the oral method. This uncertainty caused us to abandon the oral procedure for the intravenous route for introducing the dye, which change has been a source of great satisfaction, both to us and to our consulting staffs. It is with confidence that we now go to the operating room to see the gall bladder removed, if it has been reported as mal-functioning from intravenous cholecystography.

In our experience the majority of gastro-intestinal complaints are the result of cholecystic disease. In a series of eight hundred gastro-intestinal cases without cholecystography 204 or 25 per cent were found to have lesions in the stomach, duodenum or colon, whereas in a similar series the addition of cholecystography to complete the examination, 397 were found to have mal-functioning gall bladders, either with or without gall stones, a percentage of 49 per cent. Cholecystography, therefore, should be the first part of the roentgen examination of all cases with gastro-intestinal complaints, preceded only by open films of the gall bladder area for opaque stones. Too often after colon or stomach examination the roentgenologist is requested to examine the gall bladder and kidney regions, but barium in the abdomen confuses the findings in these areas, and the patient must lose two or three days getting rid of the barium before the examination can be completed.

For an accurate complete diagnostic study a further most important consideration should be mentioned. A positive or negative cholecystography examination should be followed by a roentgen examination of the remaining parts of the gastro-intestinal tract because of the frequency of a lesion in more than one organ. In our series of complete gastro-intestinal tract roentgen examinations including cholecystography, double lesions were found in 45 instances of 11 per cent, and triple lesions in 9 instances or three per cent of pathologic cases respectively.

TECHNIC

The technic here described is simple and takes very little of the doctor's time because everything but the actual injection of the dye can be delegated to the nurse. The method here discussed is modified from that used by Dr. Frank Mackoy of Milwaukee, whose careful and accurate work has always been an inspiration to those who know him.

For convenience all apparatus used in the injection, consisting of a gravity graduate, Luer Kaufman side-arm syringe, rubber tubing, an 18 and a 20 gauge needle 1¼ inches long, towels and gauze flats are made up in one package and steam sterilized, several of which packs are kept ready for use at all times. We use Mallinchkrodt's Iso-iodeikon (Phenol-tetraiodo-phthalein sodium) for three reasons: because it is less toxic than its isomer iodeikon, because a smaller dose can be used, and because a liver function test can be made at the same time if desired. The dye is dissolved in fifty cc. of freshly double distilled water, filtered, and boiled 15 minutes over a water bath. All solutions are prepared fresh the day of injection.

The patient enters the hospital about two p. m., having had breakfast and a light lunch before 11:30 a. m. At two-thirty p. m. he is given a fat meal, either an egg nog containing six ounces of cream and one egg, or one slice of buttered toast and a cup of coffee or cocoa, half cream. The fat meal is given to empty the gall bladder of concentrated bile before the injection is given. Between four-thirty and five-thirty in the afternoon he is given the dye intravenously. In our earlier work the injection was at 9:00 p. m., but later we found that just as good results are obtained with earlier injection.

The injection is by way of the median cephalic or median basilic vein by the gravity method. Great care must be exercised to avoid extravasation of the dye into the perivascular tissue. The Luer Kaufman side-arm syringe is a great help in this particularly as it allows complete visibility of the flow of solutions and permits stopping of the injection at any time and pulling blood back into the syringe to prove that the needle is in the vein. The injection is begun with one hundred cc. of normal saline, also made from fresh doubly distilled water. After a free flow of saline is established, as indicated by the clearing of the blood from the side-arm syringe, the 50 cc. of sterile dye solution is added to the saline in the gravity tube.

About fifteen minutes are consumed in the injection. Occasionally a mild systemic reaction occurs when the dye is introduced too rapidly, and a tender vein often results if the period of injection is much longer than fifteen minutes. The dye injection is followed with sufficient saline to wash out the vein, as indicated by the clearing of the solution in the side-arm syringe. After removal of the needle the skin puncture is watched with light compression until it seals itself. No dressing need be applied. Flexion of the arm with compression of the vein is avoided because this may be a cause of occasional transitory thrombosis. The patient is allowed nothing by mouth after receiving the dye except water sparingly until after the first films, which are made the following morning between 8:00 and 9:00 o'clock. If no gall bladder shadow appears the examination is complete; if a shadow is obtained the patient is given a second fat meal and a second series of films is made one hour later. The gall bladder should be smaller, but not empty, making it occasionally possible to conclusively demonstrate cholesterin stones masked by some degree of uncertainty in the previous films. The whole procedure should be done by the roentgenologist, or under his direction because any divided procedure cannot be so well controlled, and control is essential.

INTERPRETATION

The gall bladder is reported as normally functioning when a shadow is obtained about as dense as that cast by the ribs, and when the shadow is definitely smaller after the fat meal.

A faint gall bladder shadow denotes poor function and poor concentrating ability. No shadow denotes a non-functioning gall bladder. Gall stones are reported as non-opaque shadows when they are brought out by contrast with the concentrated dye. Cholesterin stones give this type of shadow, and are much in the majority. Opaque stones are reported as such, and show with or without dye because of their calcium content. Gross persistent abnormalities of size and shape of gall bladder silhouette are reported as such.

ANALYSIS OF CASES

This series begins with our first case by the intravenous method and includes all cases to and including the 800th since October, 1929. There have been no general reactions as severe in our experience as with the oral method, and the few mild ones have been transitory. Urticaria with a mild pruritus is the most frequent and occurred in 56 instances or 7 per cent of all cases. Aching joints or pain in the back occurred in 8 cases. Nausea and vomiting in two and diarrhea in one case. Local reactions at the site of injection have been of little consequence; sixteen cases of local venous thrombosis that cleared up within 24 to 48 hours with hot applications; and one case of cellulitis from accidental extravasation of dye into perivascular tissue that persisted eight days before it entirely cleared.

To compare the oral and intravenous methods 120 cases that had previously been reported non-functioning by the oral method were induced to have intravenous examination. Sixty-one of these were perfectly normally functioning by the intravenous method. Fifty-nine were mal-functioning. Faint gall bladder shadows obtained intravenously in these cases showed 20 patients with soft, non-calcium containing gall stones missed entirely by the oral method. This to us is a strong argument in favor of intravenous cholecystography. Ten normal oral examinations were repeated intravenously and found normal; however, better shadows were obtained by the intravenous method.

The result of the 800 intravenous examinations are shown in the accompanying table. Practically half (397) of the cases showed mal-function. One hundred and fifty-one were operated, including six reported as normally functioning. These six showed only a mild cholecystitis, four of them grade one or less. Ninety-nine of the 151 operated had gall stones. Of 62 reported as non-functioning gall bladders without stones, 39 contained stones at operation. These were of the transparent cholesterin type and not expected to be visualized on the x-ray film. In this group the grade of cholecystitis was the highest, as would be expected with marked impairments of gall bladder func-

FIGURE I. INTRAVENOUS CHOLECYSTOGRAPHY—ANALYSIS OF 800 CONSECUTIVE CASES

X-Ray Diagnosis	Total Reported	Surgical	Pathologist's or Surgeon's Report Cholecystitis					Stones
			I	II	III	IV	None	
Normal Function-No Stones	403	6	4	2	0	0	0	0
Non-Function-No Stones	144	62	3	12	15	2	20	39
Poor Function-No Stones	137	21	12	7	0	0	2	1
Poor Function c̄ Non-Opaque Stones	59	30	1	9	2	0	18	29
Poor Function c̄ Opaque Stones	18	10	1	1	0	0	8	10
Normal Function c̄ Non-Opaque Stones	20	11	0	0	0	0	11	11
Abnormal Size or Shape	6	2	2	0	0	0	0	0
Non-Functioning c̄ Opaque Stones	13	9	0	1	2	2	4	9
Totals	800	151	23	32	19	4	63	99
Total Mal-Function	397							
Total Stone Diagnosis	60							
Total at Operation	59							

Non-function group contained three carcinoma of the gall bladder, one of the liver and one of the stomach with wide-spread metastasis.

tion. In the operated group stones were reported from x-ray films in 60 instances, of which the surgeon found the stones in 59.

CONCLUSIONS

(1) A method for intravenous cholecystography is described.

(2) The intravenous method of cholecystography has been without severe reaction in 800 consecutive cases.

(3) The whole procedure should be under the charge of the roentgenologist.

(4) The oral method was found to be unreliable in slightly over 50 per cent of all non-functioning cases checked intravenously.

(5) Cholecystography should be a part of every gastro-intestinal examination and the intravenous technic is the procedure of choice.

External Cephalic Version*

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Breech and transverse presentations have always been recognized as serious complications. The foetal mortality has been rated from three to twenty per cent, and we have no way of knowing how many babies receive injuries at delivery affecting their later development. Extent and severity of labor is much greater, the maternal injuries are greatly increased, and occasionally a maternal death occurs in a breech delivery.

In external cephalic version we have a simple, safe method of correcting these unfavorable presentations.

The objections offered to this method are the danger of placental separation, rupture of the membranes, and prolapse or looping of the cord around the neck of the foetus. These complications are very rare as they seldom occur without the use of undue force. Rhyder (1) reports a series of fifty-nine cases of breech presentations with twenty-nine successful external cephalic versions and no foetal mortality. Rietdijk (2) of

* Presented before 90th Anniversary Meeting, State Medical Society of Wisconsin, Madison, Sept., 1931.

Rotterdam School of Midwifery accomplished three hundred seventeen successful versions out of three hundred fifty-six cases. Bartholomew (3) performed forty-nine versions on eighty-one cases. Gibberd (4) had a series of one hundred seventy-nine versions with only one case showing slight antepartum bleeding. McGuinness (5) cites fifty-seven versions out of a total of sixty-two. In all of these there were no complications such as premature separation of the placenta, prolapse of the cord, or rupture of the membranes. This indicates that a breech presentation can, in most cases, be safely converted into a cephalic position by external version.

The most favorable time for doing the version is from the seventh to the eighth month, because at that time the baby is small enough to be readily turned, and large enough, in the majority of cases, to keep its altered position.

In some cases the baby will revert again to the breech position, but an external version can be repeated a second or even a third time, unless the membranes have ruptured.

The technique of external cephalic version is as follows: The bladder and bowels should be emptied before proceeding with the version. The patient should then be placed in the Trendelenburg position to obtain the benefit of gravitation in disengaging the breech. The essential requirement for success in the version is the maintaining of flexion of the baby. This is done by moderate pressure on both head and breech while turning the baby forward. In a few cases difficulty will be experienced in turning the baby forward, and an attempt should then be made to turn it backward, maintaining flexion by pressure on the breech.

The first step is to locate the breech and head. An assistant grasps the breech with the fingers underneath and thumb on upper surface and then moves it into either right or left iliac fossa, depending on the direction of the version. If the breech is deeply engaged it may be necessary for a second assistant to raise it out of the pelvis by two fingers in the vagina or one finger in the rectum, the rectal method preferred, and as the breech is raised from the pelvis the first assistant mobilizes it from above. The breech is carried upward by the assistant and at the same time the head is carried downward by the operator. The only difficulty encountered is when the transverse position is reached, and this may be overcome by a little pressure on the head and breech, thus increasing the flexion of the baby which will carry it past the transverse axis. The version is then completed. In some cases when we have a nervous patient, a tense abdominal wall, or an irritable uterus, an anesthetic will often permit an easy, successful version when a previous attempt has failed.

At the completion of the version the head is centered over the pelvis, and by gentle manipulation combined with pressure above on the breech an attempt is made to engage the head in the pelvic inlet. After the head is engaged, two cylindrical pads about 15 inches in length are applied to the sides of the abdomen and held in place with an abdominal binder. Perineal straps are then applied to prevent the binder rolling up and allowing the pads to loosen.

The only difference in this technique and that of other operators is the use of an assistant. When the breech is once disengaged it is very easily handled, but not so the head. The movement and flexion of the head is always more easily controlled with both hands, and especially when it is under the costal margin, or the abdominal walls are tense. In these cases it is practically impossible to grasp, flex, and guide the head with one hand.

I feel certain that many of the reported failures have been due to the operator attempting the version unassisted.

REPORT OF CASES

I wish to report on fifty-two cases of breech and transverse positions.

External cephalic version was attempted in all of these cases and was successful in forty-eight. Later two of these cases came to the hospital at term in labor with the membranes ruptured and a breech presentation. In all there were forty-six out of the fifty-two cases that were terminated as cephalic presentations.

Successful versions:
At six months—7.
At seven months—19.
At eight months—22.
In labor—4.

Failure of version:
At seven months—1.
At term—1.
In labor—2.

Failure of these two cases was due to rupture of membranes when version attempted.

Cases in which version had to be repeated —4.

Successful versions in primipara—22.
Successful versions in multipara—30.
Anesthetic required—22.
No anesthetic required—30.
Prolapse of cord—None.
Looping of cord around neck—2.
Separation of placenta—None.
Rupture of membranes:
Before labor—None.
During labor—2.
Maternal deaths or serious maternal injury—None.
Foetal death:
Before birth—1.
At or after birth—None.

In the one case of prenatal death of the foetus an easy version was done on February 10, 1931. A second version was necessary on March 18, 1931. On April 26th foetal movements and foetal heart tones ceased, and a dead foetus was delivered April 31st. There were no findings to account for the death, and it does not seem reasonable to connect it with the versions as the last one was done about six weeks before.

Positions at onset of labor of cases previously turned and those in which version was done during labor:

R. O. A.—5.
R. O. P.—9.
L. O. A.—22.
L. O. T.—4.
R. O. T.—2.
Unrecorded—4.
Normal births—32.
Instrumental cases—13.
Cesarean Section—1 due to placenta praevia.

CONCLUSIONS

1. On account of the high foetal mortality in the delivery of breech and transverse presentations, their occurrence should be prevented as often as possible.
2. In external cephalic version we have an easy, safe method of changing the majority of these presentations to the cephalic position.
3. The objections raised against external version are more theoretical than practical because complications rarely occur.
4. An occasional case reverts to a breech position, but this is usually easily corrected by a second or even a third version.
5. In nervous patients and cases with tense abdominal walls an anesthetic is necessary.
6. An assistant is invaluable in most cases and many failures will occur if the operator attempts to do every version without assistance.

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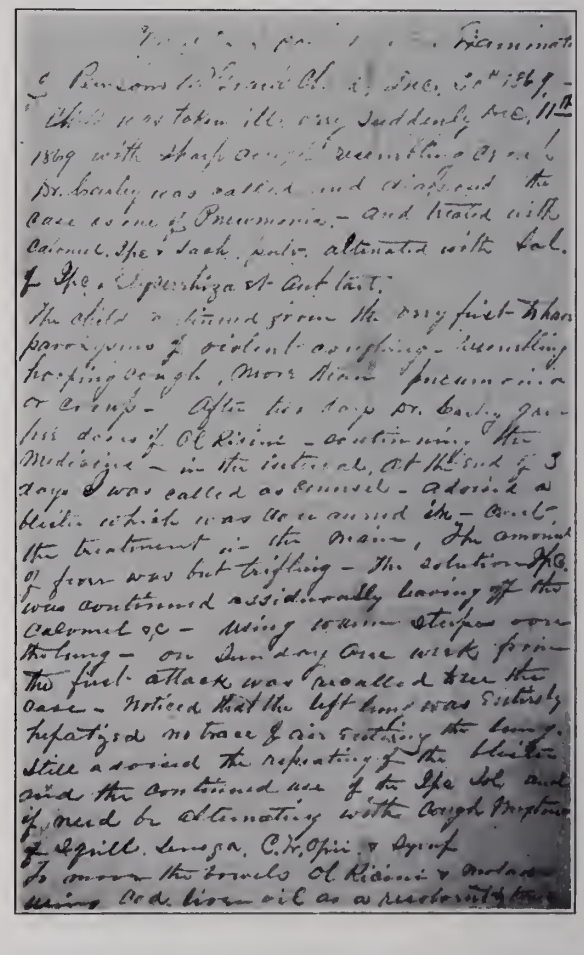
MARQUETTE UNIVERSITY ESTABLISHES GRADUATE BUREAU FOR PHYSICIANS

A Graduates' Bureau to serve physicians who are alumni of Marquette University School of Medicine has just been announced by Dr. B. F. McGrath, dean of the Graduate School. The Bureau provides information on locations for physicians; physicians equipment, offices, etc.; residences in hospitals; fellowships in clinics, research, and on the National Research Council; openings at Marquette for research and teaching, and will extend such other services as are possible to their graduates. An early response to the establishment of the Bureau has indicated the need for such a service.

THE JOURNAL CLINIC

Foreign Body in the Trachea; Minutes of a Post-Mortem Conducted by Dr. L. G. Armstrong of Boscobel in 1869

The original sheet containing this report was loaned the Journal by Dr. E. H. Spiegelberg of Boscobel. Dr. Armstrong was a former President of the State Medical Society of Wisconsin and the father of Dr. C. A. Armstrong of Prairie du Chien. Editor's Note.



"Minutes of post-mortem examination of Ransom McGraw's child. December thirtieth, 1869.

"Child was taken ill very suddenly December eleventh, 1869, with sharp cough resembling croup. Dr. Carley was called and diagnosed the case as one of pneumonia, and treated with calomel, ipecac and powdered sugar, alternated with solution of ipecac, glycyrrhiza and tartar emetic.

"The child continued from the very first to have paroxysms of violent coughing, resembling whooping cough more than pneumonia or croup. After two days Dr. Carley gave free doses of Ol Ricini, continuing the medicine in the interval. At the end of three days I was called as counsel—advised a blister which was concurred in; continued the treatment in the main. The amount of fever was but trifling. The solution of ipecac was continued assiduously, leaving off the calomel mixture, using warm stupes over the lung. On Sunday, one week from the first attack was recalled to see the case—noticed that that the left lung was entirely hepatized, no trace of air entering the lung. Still advised the repeating of the blister and the continued use of the ipecac solution and if need by alternating with cough mixture of squill, senega, camphorated tincture of opium and syrup. To move the bowels Ol Ricini and molasses using cod liver oil as a resolvent and tonic. Case continued without material change—save the child seemed better. The excessive paroxysms of coughing getting lighter and not so frequent. December twenty-fifth, 1869, Dr. Carley deemed the case convalescent; he was unable to assign a true cause of the cough. Yet through the suggestions of outsiders it was thought that there might be something in the trachea or bronchial tubes, causing the stoppage of the left bronchus. At the end of twenty-one days the child was taken with severe and continued coughing from which it died at the end of twenty hours. Eighteen hours after death a post-mortem was held. Present: Dr. Carley, Dr. Beals and Dr. Armstrong. The lungs examined, the left entirely hepatized, also the lower lobe of the right. No effusion. Abdomen not exam-

ined. Nothing found in the lungs, but by aid of a probe the trachea was examined and a kernel of corn found—much macerated and softened but entire in its structure.

"Conclusion—Death from kernel of corn in the trachea, having been coughed up out of the left bronchi eighteen hours before death."

Abrachiatism; Report of Two Cases

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This article is confined to a simple report of two cases of abrachiatism, with no effort being made to discuss the reasons pro and con for its occurrence. Two cases of complete absence of the upper extremity, distal to the scapula, occurred within a radius of fifty miles of each other. It was impossible to establish any relationship between the two families.

CASE NO. I

This child was born December 23, 1926, and died about one month later January 23, 1927. The essential deformity was a complete absence of the upper extremity, distal to the scapula. X-ray examinations revealed intact scapulae, and clavicles, with no evidence of the other bones of the upper extremities being present.

Careful anatomical dissection was made of the head, neck, chest, and abdomen of the child. No abnormalities were found in neck, abdomen, or viscera of the chest. The brachial plexus was normal in origin and distribution to the point of amputation where the branches ended in a fibrous mass to be described later. The muscles of the shoulder girdle were present and practically normal in origin, their insertion being altered of necessity because of the lack of a humerus. The pectoralis major, and minor, deltoid,

Case No. I.

Case No. I.

latissimus dorsi, teres major and minor, subscapularis, all inserted into a fibrous mass located just inferior to the lateral end of the clavicle. The supraspinous and infraspinous muscles had no tendons of insertion, the muscle fibers ending at the lateral edge of the scapula.

Just below the fibrous mass into which the muscles of the shoulder girdle inserted and in which the branches of nerves and blood vessels terminated, was found a large cartilaginous mass. Upon removal of the soft tissues this was found to be an amorphous mass of cartilage protruding from the lateral angle of the scapula embodying both the glenoid cavity and the coracoid process. The spine and the acromial processes of the scapula were present and normal.

Family History. This infant was a result of the ninth pregnancy and the sixth living child born to his mother. No history or evidence of luetic infection could be determined. There is no evidence of any children being born with any type of anatomical deformity in either the father's or mother's families.

CASE NO. II

This child was born April 4, 1929. The essential deformity which the child has is a complete absence of both upper extremities, distal to the scapulae, together with a talipes equinovarus of the right foot. The only evidence of an upper extremity was at the right shoulder, where a small, fleshy mass of soft tissue about the size and shape of a large hickory nut was found. X-ray examinations revealed intact scapulae and clavicles, but no evidence of the bones of the arm or forearm were present. A complete physical examination revealed no other abnormalities with the exception of a stenosis of the right naso-lachrymal duct.

At the present time this boy is living and in a healthy mental and physical condition with the exception of a rather severe grade of rickets which has not yielded to the usual medication. The severity of his rickets has resulted in a marked scoliosis, and has prevented his walking up to the present time. His feet have become extremely prehensile and he performs with them the tasks which the ordinary child of his age completes with his hands.

Family History. The child's mother and father were both twenty years of age and had been married one year. He was a result of the first pregnancy. The family history was entirely negative except that the husband's father's mother's brother's child was born with the absence of both legs from the knees down, and one forearm, the other arm was useless. His mental status was questionable and he died from an unknown cause at the age of thirty.

DISCUSSION

Two cases of abrachiatism are presented almost identical in character. One child died at the end of one month, the other is living in a healthy condition. No relationship between the two families could be established.

Several theories have been proposed as being the cause of abrachiatism. First: The exhaustion of pregnancy. It has been suggested from time to time that repeated frequent pregnancies might be the cause of anatomical birth deformities. However, this is not borne out by the fact that the condition does not occur more often in large families than in smaller ones. In the present instance, Case No. 1 was the result of the ninth pregnancy while Case No. II was the result of the first pregnancy. Second: There has been no proof of the suggestion that the condition was due to intrauterine or congenital disease. In neither of the two cases presented above was it possible to demonstrate any type of hereditary or congenital disease. Third: Amniotic adhesions and bands. For a long time it was held by many authorities that the various types of congenital deformities of the extremities were due to intrauterine amputation by amniotic adhesions and bands. This theory has also been largely discarded because it has been impossible to prove it. Finally: Heredity. It is largely held at the present time that the condition is due to some type of hereditary manifestation. We do not feel that it can be ascribed to a direct hereditary effect, that is, that it will recur from generation to generation according to the principles of Men-

Case No. II.

Case No. II.

delian law. However, we are convinced that abrachiatism as well as other types of congenital anatomical deformities occur as a result of mutation of the genes of the chromosomes. (Muller Experimental Mutation.)

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American Medical Association Introduces Bills in Congress to Amend Certain Provisions of Volstead Act

Identical measures have been introduced in the Senate and House of Representatives at Washington to carry into effect the desires expressed by the House of Delegates of the American Medical Association. The sole purpose of the bill introduced at the instance of the American Medical Association is (1) to remove present statutory limitations on the quantity of spirituous and vinous liquor that a physician can prescribe; (2) to remove the difficulties that now lie in the way of obtaining more than one hundred prescription blanks in ninety days; and (3) to provide by statute what has already been provided by regulation, namely, the avoidance of the disclosure of the ailments of patients incident to the filing in public offices of records naming such ailments.

The Senate bill has been introduced by Senator Copeland of New York and numbered as S3090. The House bill has been introduced as H.R. 8077.

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EDITORIALS

ROBERT KOCH

FIFTY years ago last month, March 24, 1882, to be exact, Dr. Robert Koch presented before the Physiological Society of Berlin his epoch-making paper on "The Etiology of Tuberculosis".

When the name of Robert Koch is mentioned we are wont to associate him at once with the discovery of the cause of tuberculosis. This is perhaps but natural as this discovery marked the crowning glory of Koch's career. A career that began but a few years previously in the home of an unknown physician in a small country town. In spite of the difficulties of supporting a growing family on the meagre income of a country practitioner, with practically no laboratory facilities except those of his own making, Koch nevertheless laid the foundation for his future greatness among these homely surroundings.

The medical profession, in fact the world at large, is indebted to Robert Koch for many other scientific contributions besides exposing the tubercle bacillus as the one specific agent causing tuberculosis, consumption, scrofulosis and Perlsucht. In 1876, while still a village practitioner, Koch discovered the cause and nature of anthrax, which disease had been destroying herds of cattle and sheep for years, and interfering greatly with the successful raising of these animals in Germany and France. Two years later Koch showed that wound infections were due to bacteria, and in 1881, now Associate Health Officer in Berlin, came the announcement of the wonderful plate method of culturing and isolating bacteria. This invention, because of its simplicity, did more than any other one factor to lay the foundation of the new science of bacteriology.

In 1883 Koch went to Egypt and India to study Asiatic cholera and returned one year later with the information that the cause of cholera was a specific germ called the cholera bacillus. He was awarded the Nobel prize for his many valuable contributions to bacteriology and scientific medicine. Dr. Koch died May 27, 1910.

In commemoration of the 50th anniversary of the discovery of the cause of tuberculosis, the National Tuberculosis Association has published a translation of Koch's original paper "The Etiology of Tuberculosis". In this paper, called by Krause "a perfect original medical paper", every step of Koch's work is explained logically and ingeniously. "Not only for his discovery but for his method of presentation did Koch in this paper contribute a scientific masterpiece of all time."

The Wisconsin Anti-Tuberculosis Association will gladly send, upon request, any interested physician or library a copy of this illustrated translation. O. L.

CHRONIC NEPHRITIS AND THE LIVER

THE etiology of chronic nephritis remains an enigma despite an ever increasing interest in and study of the disease. That infection is an important factor is well recognized, but conclusive evidence of its presence or etiological relationship is lacking in most cases. Some investigators ascribe an important role to certain errors in diet, particularly excessive protein intake or some perversion in its metabolism. Thus far no unanimity of opinion has been reached regarding even these two possible factors.

Pursuing his original work on the effect of high protein feeding upon experimental animals, Newburgh has been able to demonstrate that certain amino acids are highly nephrotoxic while others are not. It is very evident that this observation is highly significant in any discussion of the relationship of protein foods to chronic nephritis. With this consideration in mind, the quantity of protein ingested is of importance in proportion to the relative amount of toxic amino acids or other intermediary nephrotoxic material which it is capable of elaborating. Furthermore, errors in the digestion, absorption, utilization and ultimate detoxification of this potentially toxic material in the various organs, particularly in the liver, may subject the kidneys to additional strain in the process of elimination. That the liver is of especial importance under such conditions is made more probable by the well established fact that one of its important functions is the conversion of the ultimate products of protein metabolism into urea before elimination by the kidneys.

Knowing, as we do, the enormous reserve of the liver, and faced with inadequate means of discovering functional derangements save of the most advanced type, it is possible that relative degrees of functional incapacity with respect to protein metabolism may exist and escape clinical detection until some vital system is seriously impaired. If incomplete detoxification of such material subjects the renal tissues to an injurious influence over a protracted interval of time, such insidious damage may be an important factor in the ultimate degenerative changes of chronic nephritis.

Such a possible interrelationship of function is further suggested by recent experimental work of Hanner and Whipple.* After producing necrosis of the liver with chloroform, they found a distinct rise in the elimination of phenolsulphonphthalein by the normal kidney. The damaged liver does not remove any of the dye from the blood stream or excrete it in the bile as it normally does. They conclude that an unusually high renal elimination of the dye should suggest possible liver damage, and, furthermore, in combined renal and liver disease, considerable caution should be used in the interpretation of this test.

This change in integration of responsibility between the liver and kidneys under experimental conditions may give some indication of the infinite variety of disturbances in balance possible in response to intercurrent or focal infections, digestive errors, functional derangements of the liver and gross vagaries of the diet. It makes it all the more evident why our understanding of chronic nephritis is in such a state of confusion at this time. J. H.

* Elimination of Phenolsulphonphthalein by Kidney: Influence of Pathologic Changes in Liver, J. P. Hanner and G. H. Whipple, Archives of Internal Medicine, 48:537; 10/31.

THE HOSPITAL SITUATION

THE present economic situation and its effect upon hospitals was naturally the center for long discussion at the recent joint meeting of the Illinois, Indiana, and Wisconsin Hospital Associations at Chicago. It is of interest to our physician readers to know that the discussion resolved itself into three outstanding conclusions:

1. The large amount of space given to a discussion of hospital and medical costs in lay publications in the past three or four years has created in the lay mind the feeling that *any* cost of illness is too high.

2. The real problems of hospitals very largely can be solved outside of legislative halls.

3. The truly indigent should be the community responsibility and charitable aid might better be extended those who, even though handicapped, are endeavoring to pay their way.

THE PRESIDENT'S PAGE

BE SURE YOU ARE RIGHT AND THEN GO AHEAD

AT THE last meeting of the State Medical Society it was pointed out that there is at present a rather widespread criticism of the distribution of medical service. However, the fundamental facts and data appertaining hereto were either not available or insufficient to warrant the Society in drawing any definite conclusions. There was therefore introduced and passed in the House of Delegates a resolution which provided for the appointment of a committee to study this subject and to report back to the next session its findings. The President at that time pointed out that it might not be possible to have a sufficiently intensive or extensive survey within the year to make possible a report at the meeting of 1932, and that in any event the study must go forward, if undertaken, until we have positive information as a basis from which proper conclusions may be drawn. We believe that this procedure was most commendable and that, before organized medicine should take any definite position, it is necessary that it should have all the information possible before it.

Just now there is a movement on foot to send delegates to the meeting of the House, the coming session, who shall be definitely instructed to vote in a certain way on a controversial subject of great interest and great importance to the profession of the State. Are all the facts, all the data from which a rational and fair conclusion may be drawn, secured and available? Is such action as is proposed so well founded in the evidence that we are justified at present to take a positive stand? Are we absolutely sure of our ground?

This matter was before the Council two years ago. At that time a committee of three with Dr. Arthur Rogers, Chairman of the Council, as chairman, made a survey on the admission of clinic cases to the State Hospital. Much of the work of this committee and the report were submitted by our Secretary. According to the facts then established, there seemed to be no real ground for much of the criticism and if criticism was justified, it was directed against our own membership. In other words, such faults as were exposed in the study of 100 consecutive clinic cases, revealed that where injustice and unfairness were demonstrated, it was due to the action of the physician who, over his signature, had vouched for the fact that the patient could not pay for medical care and could only afford remuneration for the hospital per diem. It is altogether likely that the hospital can more carefully scrutinize such applications and by securing a credit rating of the applicant, (which should be done at his own expense), assure itself that the patient really belongs to the class that is entitled to the benefits afforded.

The second proposition of asking for legislation which shall secure to the local hospital a subsidy not to exceed $2.50 per diem for indigents locally hospitalized, likewise has its dangers. Can the State be asked to appropriate from two to three millions a year when it has no control over the expenditure? Would it be better to have the County assume the total cost of care of the patient at the State Hospital? In this event the County Judge would be less ready to send him to the State Hospital. Is the present method of dividing the cost best? Would it not be advisable to have further facts before we reach positive conclusions? Moreover, we must consider what the reaction of the legislators will be if the profession comes to Madison to ask that the State shall appropriate the huge sum of money necessary to hospitalize indigent patients in the local hospitals.

The Council, after long deliberation, was not able to answer these questions, and, at its meeting on April 23rd, appointed a committee consisting of President-Elect Reginald Jackson of Madison, Frank Pope of Racine, and S. E. Gavin of Fond du Lac, with Gunnar Gundersen of La Crosse, Regent of the University, acting in an advisory capacity, to make further studies, secure the necessary data, compile the same, and present its findings to the House of Delegates at its next session, so that it may act wisely and to the advantage of the profession in whatever it shall do.

In view of all this, would it not be best for the delegates to the House to come with open but critical minds, ready to weigh all the evidence, all the facts, and then act with full knowledge, or as full knowledge as can be attained by further study in the solution of this vexatious problem? Instructed delegates to any meeting are bound so that they are unable to weigh evidence and render judgment. This is a dangerous procedure not only in this matter, but in any other matter that may be brought before the House of Delegates.

Let every member of the profession in the State gather all the possible evidence pertaining to this subject and present it to the committee, so that it may have as large a material as possible on which to base conclusions and its report. At any rate, it behooves us to be sure that we are right before we proceed.

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SOCIETY PROCEEDINGS

BROWN-KEWAUNEE

Members of the Brown-Kewaunee County Medical Society met at the Hotel Beaumont, Green Bay, for a dinner meeting on March 24th. Following the dinner, Dr. W. C. Carroll, head surgeon of the St. Paul Clinic, presented the subject "Cervical Ribs and Anomalous First Thoracic Ribs." A general business meeting was also held.

EAU CLAIRE

The Eau Claire and Associated Counties Medical Society held a meeting at Hotel Eau Claire, Monday evening, March 28th.

After the dinner at six-thirty o'clock, the following scientific program was presented:

"The Displacement Method of Diagnosis in Nasal Accessory Sinus Disease" by Drs. F. S. Cook, J. C. Baird, and P. G. Spelbring, all of Eau Claire. This was discussed by Dr. A. L. Payne and Dr. J. Y. Malone.

"Neurological Aspects of Primary Anemia" by Dr. Richard S. Ahrens of Minneapolis, with discussion by Dr. R. E. Mitchell, Eau Claire.

FOND DU LAC

Dr. D. J. Twohig, Fond du Lac, was elected delegate to the State Society meeting to succeed Dr. S. E. Gavin, resigned, at a regular meeting of the Fond du Lac County Medical Society held on April 13th at the Hotel Retlaw. Dr. Gavin resigned because of his recent election as district councilor of the State Medical Society of Wisconsin.

After the business session, which was preceded by a six-thirty o'clock dinner, members of the Society heard an address by Dr. Albert H. Andrews, Chicago. His subject was "Diseases Associated with the Facial Nerve."

GREEN

A meeting of the Green County Medical Society was held in the offices of Drs. Gnagi of Monroe.

Papers were presented by Dr. M. F. Stuessy, Blanchardville, who spoke on "Non-surgical Treatment of Varicose Veins", and Dr. M. P. Ohlsen of Monticello who discussed "Perinephritic Abscess."

KENOSHA

At the regular meeting of the Kenosha County Medical Society held Thursday evening, April 21st, Dr. Irving F. Stein of Chicago was guest speaker. He presented an interesting paper, supplemented by lantern slides, on "The X-ray Diagnosis of Early Pregnancy." W. H. L.

MARINETTE-FLORENCE

Members of the Marinette-Florence County Medical Society met Thursday evening, January 21st, at the Hotel Marinette. The following addresses were given:

"Spore Dust Infection of Lungs" by Dr. John Wm. Towey, Powers, Mich.

"Lung Pathology" by Dr. Sweeney of the Chicago Municipal Hospital, Chicago.

A joint meeting of the Marinette-Florence and Menominee County Medical Societies was held at the Hotel Menominee, Menominee, Mich., February 18th. After the dinner at six-thirty o'clock, the following program was presented:

"Treatment of Burns" by Dr. L. E. Hamlin of Norway, Mich.

"Resume of Some Recent Advances in Treatment of Childhood Condition" by Dr. M. Cooperstock, Marquette, Mich.

On March 24th, the Marinette-Florence County Medical Society held a joint meeting with the Woman's Auxiliary, at Hotel Marinette.

Dr. Jessie P. Allen of Beloit gave an address on "The Value of the Auxiliary to the State Society."

Dr. F. W. Mackoy of Sacred Heart Sanitarium, Milwaukee, spoke on "X-ray Diagnosis With Film Demonstration."

Dr. R. W. Shaw, Marinette, presented "Tularemia With Case Report."

MILWAUKEE

The monthly meeting of The Medical Society of Milwaukee County was held in the Crystal ball room of the Schroeder Hotel on Friday evening, April 8th.

Dr. P. M. Currer, president of the Society, made the opening address on contract, corporate, and panel practice in Milwaukee County, stating his views on the subject. At the conclusion of his talk Dr. Currer introduced a resolution providing that the County Society memorialize its parent organizations,—the State Medical Society and the American Medical Association,—urging them to make a thorough study of contract, corporate, and panel practice to the end that all that is objectionable to the public and medical profession be eliminated; further, that the board of directors of the County Medical Society be authorized to expel any of its members who participate in contract, corporate, or panel practice where the fee is so low that physicians cannot render adequate medical service to the public, and where it interferes with reasonable competition among physicians of the community. This resolution was carried by a large majority.

Dr. T. C. Galloway, assistant professor of oto-laryngology at the Northwestern University Medical School, was the principal speaker of the evening. His subject was "Surgical Diathermy in Oto-laryngology." Dr. Galloway's paper was discussed by Drs. J. E. Guy and Ralph P. Sproule.

Dr. Norbert Enzer, pathologist at Mt. Sinai Hospital, spoke on "The Relationship of Pathology to the Practice of Medicine." Dr. Enzer's paper was discussed by Dr. M. Fernan-Nunez.

Following the scientific program the meeting was adjourned to the social hour.

There were about 250 members present.

ROCK

The Rock County Medical Society held its monthly meeting in the Myers hotel, Janesville, at six-thirty o'clock, March 29th.

Following dinner, two Chicago physicians addressed the group. Dr. James H. Hutton spoke on "The Place of Endocrine Therapy in Daily Practice," while Dr. Phillip H. Kreuscher discussed "Fractures Near the Joint."

WALWORTH

At the April meeting of the Walworth County Medical Society held in the Y. M. C. A., at Lake Geneva, Dr. G. H. Fellman of Milwaukee addressed the members on the subject of "Pyloric Stenosis." Following his address a short business session was held for the purpose of presenting to the Society the resolution of the "Seven Counties." There was much general discussion but definite action was postponed until the May meeting of the Society. V. S. D.

MILWAUKEE ACADEMY OF MEDICINE

At the April 19th meeting of the Milwaukee Academy of Medicine, the following program was given:

1. Presentation of cases, specimens and roentgenograms of Gaucher's Disease by Dr. Norbert Enzer.
2. The Management of Cerebral Trauma and Intracranial Pressure by Dr. Temple Fay, professor of neurological surgery, Temple University School of Medicine, Philadelphia.

The following memorial note was accepted by the Academy at this meeting on the death of Dr. Gustave J. Kaumheimer:

"The death of Doctor Gustav J. Kaumheimer on March 12, 1932, removes from the roll of the Milwaukee Academy of Medicine one of its honored and oldest members, and in presenting this memorial of his life the Academy pays a last tribute of respect.

"Doctor Kaumheimer's active and beneficent medical life extended over almost half a century and embraced the period in which occurred the development of modern medicine. Inspired early by the stimulating and formative contact with leaders in medicine of the time, he retained throughout his professional life an absorbing interest in medicine and its progress, and exhibited a characteristic loyalty to duty and to the best traditions of medical practice.

"Doctor Kaumheimer was a practitioner of the old school, essentially the wise and helpful counsellor in time of sickness and of adversity, and as such will be held in grateful remembrance by his patients.

"His colleagues will retain the memory of a distinctive personality—friendly, kindly and helpful, especially to younger men; companionable and modest, with views tempered by much experience; skillful and wise in the art of medicine, and intensely loyal to principles and to those marked by him for his friendship and esteem.

"Doctor Kaumheimer was born in Philadelphia on August 4, 1862, and came to Milwaukee with his parents at the age of seven. Under the preceptorship of Doctor Nicolas Senn he attended the College of Physicians and Surgeons in Chicago and received the degree of Doctor of Medicine in 1887. He then served as interne in Cook County Hospital for two years and for a similar term in Milwaukee County Hospital, before beginning practice in Milwaukee in 1891.

"Thereafter much of Doctor Kaumheimer's professional life was centered in Milwaukee Hospital to which he gave liberally of his time and experience. He was a member of the staff of Milwaukee Hospital for 35 years, and for 33 years was secretary of the staff—a position that was his great pride. He was active in local medical affairs for many years and was president of the Brainard Medical Society in 1907 and president of the Medical Society of Milwaukee County in 1919. During 1907 he was president of the Academy of Medicine.

"When death claimed Doctor Kaumheimer within a day of the death of his wife, who had been his steadfast helpmate throughout the years of his professional life, it came as a release from a long period of suffering endured with the quiet fortitude of a truly courageous man.

"Be it resolved, that as a tribute of respect the Milwaukee Academy of Medicine record this Memorial Note upon the minutes, that a copy be transmitted to the family of Doctor Kaumheimer, and that the Academy, through the secretary, extend its sympathy in their loss of father and mother to the children of our late member."

Leopold Schiller,
Otto H. Foerster,
G. H. Fellman,
Chairman of Committee.

MILWAUKEE OTO-OPHTHALMIC

The April meeting of the Milwaukee Oto-Ophthalmic Society was held at the Wisconsin Club on April 26th following a dinner at six-thirty o'clock.

Dr. Leo L. Mayer of Chicago was speaker of the evening, his subject being "Modern Methods in Strabismus; Orthoptic Treatment and Indications for Operative Treatment."

MILWAUKEE PEDIATRIC

At the monthly meeting of the Milwaukee Pediatric Society, held at the Milwaukee Children's Hospital on April 13th, the following program was given:

"Pertussis" by Louis W. Sauer, M. D., Evanston, Ill.

"Otitis Media and Sinusitis in Infants and Children" by George B. Light, M. D., Milwaukee.

UNIVERSITY OF WISCONSIN

Dr. William Snow Miller, emeritus professor of anatomy, University of Wisconsin, gave an illustrated lecture on "The Life and Times of Dr. William Beaumont" on Tuesday evening, April 19th, in the Service Memorial Institutes building, Madison. The lecture was sponsored by Sigma Sigma, honorary medical fraternity, and was open to the public.

THE WOMAN'S AUXILIARY

Mrs. Orvil O'Neal, Ripon, Editor

The organization meeting of the Woman's Auxiliary to the Winnebago County Medical Society was held at Oshkosh on April eighteenth. Mrs. R. H. Bitter of Oshkosh presided and spoke on "The Aims and Scope of a Woman's Auxiliary". Mrs. Orvil O'Neal of Ripon told of the work of the Green Lake–Waushara–Adams Auxiliary.

The following officers were elected: Mrs. J. W. Lockhart, Oshkosh, President; Mrs. R. H. Bitter, Oshkosh, Secretary and Mrs. H. F. Beglinger, Oshkosh, Treasurer.

* * *

The Auxiliary and the Doctors of the Marinette–Florence County Society met at Hotel Marinette on March 24th. After dinner, Dr. Jessie Allen, Beloit, spoke on the "Value of an Auxiliary to a County Medical Society".

* * *

The monthly meeting of the Woman's Auxiliary to the Medical Society of Milwaukee County was held at the Shoreerest Hotel on April 8th. Dr. Paul M. Currer, President of the Society, opened the meeting with a brief talk, after which the group was addressed by Dr. Otho A. Fiedler on the "Distribution of Medical Service in Wisconsin".

NEWS ITEMS AND PERSONALS

Wisconsin physicians who read papers before various sections at the meeting of the American Medical Association held in New Orleans, May 9th to 13th, included the following:

Dr. Joseph F. Smith, Wausau, discussed a symposium on traumatic and industrial surgery, and Dr. G. V. I. Brown, Milwaukee, discussed a paper on "Essential Factors in the Ideal Cleft Palate Operation," before the Section on Surgery, General and Abdominal.

Dr. F. Herbert Haessler, Milwaukee, opened a discussion on "A Contribution to the Pathology of Retinitis Pigmentosa with Special Reference to the Phagocytic Activity of Müller's Fibers" before the Section on Ophthalmology.

Dr. M. G. Peterman, Milwaukee, presented a motion picture demonstration on "Convulsions in Childhood" before the Section on Diseases of Children.

Dr. M. H. Seevers and Dr. Ralph Waters, both of Madison, presented "Respiratory and Circulatory Changes During Spinal Anesthesia (Lantern Demonstration)" before the Section on Pharmacology and Therapeutics.

Dr. Hans H. Reese, Madison, opened a discussion on the paper "Experiments with Therapeutic Aids in a Psychiatric Hospital" which was read before the Section on Nervous and Mental Diseases.

Dr. George H. Ewell, Madison, presented a paper on "Cystine Nephrolithiasis (Lantern Demonstration)" before the Section on Urology.

Before the Section on Orthopedic Surgery, papers were read by the following:

Dr. C. C. Schneider, Milwaukee, who spoke on "Acromioclavicular Dislocations: Autoplastic Reconstruction (Lantern Demonstration)"; Dr. F. J. Gaenslen, Milwaukee, opened the discussion on "Closure of Chronic Osteomyelitic Cavities by Plastic Methods (Lantern Demonstration)," and Dr. L. D. Smith, Milwaukee, discussed a paper on "Injuries to the Internal and External Lateral Ligaments of the Knee: A Conservative Method of Treatment."

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Dr. J. J. McCarthy of Sun Prairie visited the Bermuda Islands during April.

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Dr. A. T. Johnson of Sauk City is regaining his health at a Madison hospital. During his illness, Dr. Harold A. Baehhuber of Reeseville is taking care of his practice.

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When the new Columbus Clinic was opened early in April, it marked the first venture of its kind in the city. Members of the clinic include Drs. H. M. Caldwell, E. L. Watson and Raymond C. Howe, dentist.

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Dr. Guy W. Carlson, Appleton, addressed a meeting of the Parent–Teacher Association of Edison school, on the care of children's colds.

Dr. G. L. Baker, formerly of Rib Lake, has moved to Westby.

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Dr. Gustave Windesheim, Kenosha, addressed the industrial health and nursing section of the Rock River Valley Safety Conference, held in Madison on May 10th. Dr. Windesheim spoke on "Cooperating with Health Agencies."

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Dr. John F. Stein, Oshkosh, has been promoted to the grade of major in the Reserve Corps, U. S. Army.

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Dr. Philip Fox, Madison, celebrated his 92nd birthday on March 27th at his home. Dr. Fox, who is the godfather of Governor La Follette, retired in 1920 after forty-four years' practice in Madison.

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Dr. W. C. Roth, Racine, has been named a member of the board of directors of the Racine Community Chest.

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Dr. C. A. Harper, Madison, on April first started his 29th year as state health officer of Wisconsin. He was first appointed by Gov. R. M. La Follette, and reappointed by Governors Davidson, Philipp, Blaine and Kohler.

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Dr. C. M. Gleason, Manitowoc, gave an address before the Kiwanis Club of Manitowoc on April 5th.

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Dr. R. C. Buerki, president of the Wisconsin Hospital Association, conducted a round table conference at the meeting of the Illinois, Indiana and Wisconsin Hospital Associations which met in Chicago on April 27th–29th.

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Dr. Arnold S. Jackson, Madison, will be a speaker on the program of the American Association for the study of Goiter which meets in Hamilton, Ontario, June 14, 15, and 16.

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Dr. O. N. Mortensen, Wisconsin Rapids, on April first announced Dr. Wallace L. Nelson as his successor in the practice of surgery and medicine.

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Manitowoc American Legion members will demand local hospitalization of veterans as against federal plans for an extensive program of hospital construction. This action was taken following an address by Dr. Otho A. Fiedler, Sheboygan, who is a member of the auxiliary committee of the legislative committee of the American Medical Association.

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Members who visited the offices of the State Medical Society during April included Dr. S. M. B. Smith of Wausau and Dr. Wilson Cunningham, Platteville.

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Dr. A. T. Smedal, Madison, opened offices in the Falk Drug store building at Stoughton on May first.

Dr. C. F. Dull, Richland Center, was re-elected health commissioner for the city of Richland Center for the next two years.

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Dr. and Mrs. W. M. Nesbit of Madison visited in New York City the latter part of April.

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Dr. A. J. Pullen of Fond du Lac will return on May 15th from a cruise around the world which started from New York on January 6th. He was accompanied by his daughter, Miss Demaris. Thirty countries were visited on this cruise which included many ports north and south of the equator.

At Hongkong, they were entertained at dinner by Dr. Arthur Wac Lak Woo, president of Hongkong University, and Dr. David T. Z. Joi, a leading surgeon of Hongkong. Both are graduates of Johns Hopkins University.

In a communication to friends, Dr. Pullen reported that he had the privilege of visiting many hospitals and examining patients while on this trip and of studying tropical diseases, those in Africa, India, and on the Island of Java being especially interesting to him.

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Dr. J. C. Wright, Antigo, secretary of Langlade County Medical Society, is remaining a few weeks at Dr. Lynch's Sanatorium, Milwaukee, for observation and treatment.

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MILWAUKEE

Dr. Eleanore Cushing-Lippitt was elected president of the George Washington University Alumni Club of Milwaukee, formed at a meeting at the City Club on April 8th. Dr. M. W. Sherwood was made a director of the club.

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Dr. H. O. McMahon returned to Milwaukee about the middle of April from a visit at Columbus, Ohio.

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Dr. M. A. Bussewitz, professor of physiology at State Teachers' College, addressed the Lions' Club at their meeting on April 11th, on the subject of "Education and World Problems."

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Dr. and Mrs. Harry Sifton returned in mid-April from a trip to Bermuda.

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Dr. and Mrs. S. H. Wetzler returned to Milwaukee on April 5th from a several months' trip in Europe. With them returned their daughter and son-in-law, Dr. and Mrs. Michael Shutkin. Mrs. Shutkin's illness called Dr. and Mrs. Wetzler to Berlin some months ago.

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Milton Spitz, Jr., son of Dr. and Mrs. M. M. Spitz, returned to Dartmouth College on April 5th, after spending his spring vacation with his parents.

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Dr. Benjamin Schlomovitz, lecturer in pathology at Marquette University, addressed the round table

group at the Jewish Center on March 27th. His topic was "Jewish Medicine".

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Dr. and Mrs. Stanley J. Seeger and their young daughters, Hannah and Mary, returned to Milwaukee April 9th, after spending several weeks near San Antonio, Texas.

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Dr. and Mrs. Harold T. Holbrook left Milwaukee April 6th for a ten day trip to French Lick Springs, Indiana.

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Mr. Theodore Wiprud, executive secretary of The Medical Society of Milwaukee County, spoke before the Knights of the Round Table at their meeting held at the Wisconsin Hotel on April 6th. He addressed the group on "Doctors, As You See Them."

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Dr. and Mrs. William L. Herner left on April 10th for Tucson, Arizona, where they expect to spend about a month.

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Dr. and Mrs. Edwin C. Bach returned on April 9th from a two weeks' trip to Florida.

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Dr. J. C. Sargent, president-elect of The Medical Society of Milwaukee County, talked on "Personal Hygiene" at a meeting sponsored by Kraenzlein Hi-Y Club, held at the Plymouth Congregational Church on April 12th.

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At the staff conference of the Norwegian-American Hospital Foundation, April the 8th, Dr. Edward H. Mensing, attending surgeon of the Veterans' Hospital, spoke on "Diagnosis and Treatment of Intestinal Obstruction."

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About four hundred persons attended the opening of the new wing of the Columbia Hospital Sunday, April 10th.

The new addition has a bed capacity of seventy-two, of which sixty are adult beds. This wing was completed at a cost of $140,000. The top floor has been set aside for interns' quarters.

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At the meeting of the Milwaukee Dietetic Association at the Y. W. C. A., on April 6th, Dr. L. M. Warfield spoke on "Some New Ideas Regarding Diet."

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Dr. Wilbur LeCron spent the week of March 28th in Baltimore, Maryland, as the guest of Dr. and Mrs. S. Leslie LeCron.

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Dr. R. S. Cron has recovered from his long illness and, upon his return from a California trip the latter part of March, again took up his practice in his office at 425 E. Wisconsin Ave.

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The first health certificate to be issued by the health council of The Medical Society of Milwaukee County was presented to Mr. Henry G. Schewe of the Weigle-Schewe Drug Company on March 19th. Since that time several other institutions handling food have signified their interest in coming under the Society's plan, and have expressed their desire to join the movement sponsored by the Society to safeguard the health of the public.

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Representing the Speakers' Bureau of The Medical Society of Milwaukee County, Dr. Harvey E. Webb addressed the Parent-Teacher Association of the Hawley Street School on April 1st, on the subject of "Normal Living."

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On April 4th, Dr. L. M. Warfield appeared before the members of the Professional Men's Club, where he spoke on "Newer Developments in Bacteriology."

Dr. Warfield also spoke before the Rotary Club of West Allis, April 7th, on "What You Should Know About Your Heart."

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Dr. Robert W. Blumenthal was the principal speaker at the meeting of the West Allis Rotary Club on April 13th. His subject was "Insuring Your Health."

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The first annual dinner dance, sponsored by The Medical Society of Milwaukee County and the Woman's Auxiliary, will be held at the Wisconsin Club on April 30th. The affair is to be informal with dinner at 8:30 P. M., followed by dancing, with bridge for those who do not wish to dance.

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Dr. and Mrs. Rock Sleyster of Wauwatosa have returned from their western trip. They have been enjoying a tour of California and Texas for the past few months.

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Dr. and Mrs. E. L. Tharinger returned the early part of April from a sojourn in Florida.

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Dr. A. H. Lahmann has been confined to his home for the past few weeks with scarlet fever.

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Dr. J. G. Slaney left Milwaukee about the first of March for Tucson, Arizona, to take up work with the United States Veterans' Hospital of that city.

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At a meeting of students from foreign lands, held in the International House of the Y. W. C. A. on April 21, Dr. M. Fernan-Nunez, formerly connected with the University of Madrid, Spain, was one of the speakers.

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Mrs. Victoria Adamkiewicz, mother of Dr. Joseph J. Adamkiewicz, passed away at her home, 1747 S. Twenty-first Street, Milwaukee, on Tuesday, April 19th.

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Dr. and Mrs. D. P. Thill have announced the approaching marriage of their daughter, Miss Anita, which will take place on May 25th, at St. Ann's Church, Milwaukee.

Dr. Chester M. Echols returned about the middle of April from a fishing trip in the Florida Keys.

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Dr. and Mrs. W. Thorndike recently enjoyed a several weeks' trip to Charleston, South Carolina. They returned to Milwaukee in mid-April.

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Mr. Theodore Wiprud, executive secretary of The Medical Society of Milwaukee County, is again presenting the lectures he gave last year to the senior class of the Marquette University Medical School. His subject on April 25th was "Medical Practice in a Changing World," and on May 2nd he will address the students on "Organized Medicine Meets Current Problems".

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The following members of The Medical Society of Milwaukee County appeared for the Speakers' Bureau, sponsored by the Educational Committee of the Society, during the month of April:

Dr. D. W. Roberts addressed the Parent-Teacher Association of the St. Robert's School on April 18th, on the subject of "Mental Hygiene in Adolescence."

Dr. Frances Johnson spoke on "Prenatal Care" at the Bureau of Home Nursing on April 20th.

At a meeting of the Center Street School Pre-School Club on April 21st, Dr. D. W. Roberts spoke on "The Technic of Parenthood."

Dr. Carl W. Eberbach appeared before the nurses of the Bureau of Home Nursing on April 25th. The subject of his address was "The Goitre Problem in the Great Lakes District."

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At the meeting of the Health Council of The Medical Society of Milwaukee County on March 17th, Dr. Millard Tufts outlined his plan for the reorganization of nursing organizations in Milwaukee County, which previously had been presented to leaders of nursing groups for their consideration, and which had been approved by them. This proposed plan was favorably accepted by the Council. It was moved that Dr. Tufts and Reverend H. L. Fritschel, Superintendent of the Milwaukee Hospital, be appointed to develop a definite plan for the reorganization of nurses, in cooperation with the leaders of nursing groups in Milwaukee, and that they call in any members of the medical profession or hospitals to assist them in this work.

Council members agreed that a report of the action taken by the Milwaukee Hospital Superintendents' Organization, relative to the handling of emergency cases by private hospitals, be given at a later meeting.

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The Educational Committee at its meeting on March 29th, made final plans for the opening of the course in chest diagnosis, and selected the instructors for this course.

Further consideration was given to the classification of Milwaukee physicians, according to their types of practice, and instructions issued regarding this phase of the Committee's work.

The Social Medicine and Medical Economics Committee met in the Mariner Tower on April 14th, and consideration was given to a statement circulated among policyholders of the Employers Mutual Liability Insurance Company of Wausau, entitled "Keep Compensation Costs Within Reason," wherein figures were given for medical costs for the years 1920–30. The Committee considered these figures unjust, and expressed themselves as resenting the implication that physicians were making excessive charges for their services at this time. Committee instructed that this company be requested to furnish to the Society a statement describing how they determined these costs.

The proposed study of contract and panel practice in Milwaukee County was discussed, and the questionnaire to be sent out in this connection, considered and revised.

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When the Physicians' Service Bureau Membership Committee met in the Mariner Tower on April 13th, reports were given by members as to the success of their personal contacts with prospective Bureau members, and plans for adding new members to the present list of Bureau subscribers were discussed.

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The special committee on the Care of the Indigent met in the Mariner Tower on April 15th, at which time a communication from Mr. W. L. Coffey, Manager of Milwaukee County Institutions, regarding the plan of The Medical Society of Milwaukee County for the care of Milwaukee County indigent, was read, in which Mr. Coffey said that the County did not favor the plan submitted by the Society. No alternative plan, however, was offered or suggested by the County.

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The Committee was informed by the Secretary that the Milwaukee Real Estate Board had requested the Society to appoint a group to join the Real Estate Board's Committee on Public Health to consider the cost of health service in Milwaukee County with the hope of eliminating duplication and consolidation of health departments, where possible. This plan met with the approval of the Committee.

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Dr. Samuel Plahner, on March 20th, addressed the members and guests of the German Press Club on "The Causes and Prevention of Juvenile Criminality."

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The wedding of Dr. Raymond P. Wiessen and Miss Carolina A. Preiss, daughter of Mrs. Emma Preiss, will take place on June the fourth.

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The following health talks, sponsored by the State Board of Health, and delivered by Mr. Theodore Wiprud, executive secretary of The Medical Society of Milwaukee County, will be broadcast over The Milwaukee Journal Station, WTMJ, during the month of May:

May 4, "Have You Learned to Walk?"

May 11, "Diseases Transmitted by Dogs and Cats."

May 18, "After-Care of Infantile Paralysis."

May 25, "Medical Cooperation."

All broadcasts will be given at 5:40 P. M.

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Dr. James C. Sargent, President-elect of The Medical Society of Milwaukee County, addressed the Knights of the Round Table on April 20th, on "The High Cost of Sickness."

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The final postgraduate course, "Chest Diagnosis," sponsored by the Educational Committee of The Medical Society of Milwaukee County, got under way on April 9th, under the following instructors: Drs. A. A. Pleyte, W. B. Ford, W. J. Egan, C. H. Stoddard, George Ernst, Karl E. Kassowitz.

The following Society members enrolled for this course: Drs. W. L. Stranberg, W. B. Walton, G. J. Schulz, Paul C. Wagner, Joseph Gramling, T. H. Rolfs, John F. Blair, W. F. Weingart, F. J. Stirn, A. F. Kusterman, H. Rasmussen, Gordon J. Schulz, E. C. Heifetz, R. J. M. Russell, D. C. Ausman, L. P. Stamm, E. F. Peterson, Ralph T. Rank, Weber C. Hermann, E. J. Panetti, G. H. Hoffmann, J. E. Rueth, R. A. Toepfer, Bruno Warschauer, L. T. Gilmer, A. W. Ladewig, E. F. Cook, Wm. A. Ryan, P. J. Eisenberg, M. M. Spitz, Wm. P. O'Malley, Frank C. Margoles, F. J. Korthals, P. E. Aszman, N. F. Dettmann, N. J. Wegmann, Louis A. Eisenberg, Bernard Krueger, Arthur C. Hansen, John J. McGovern, F. J. Kozina, S. Spilberg, J. R. Dundon, C. W. Harper, F. M. Scheele, H. E. Bardenwerper, H. C. Russell, H. J. Kuhn, Lester M. Brooks, Maurice Olsen, Benjamin Lieberman, E. T. Harrington, P. L. Callan, E. N. Pfeffer, C. D. Jurss, Millard Tufts, R. A. Waite, P. H. Perlson, E. B. O'Leary, E. L. Belknap, A. L. Bork, E. J. Schelble, L. A. VanElls, R. W. Garens, B. J. Malnekoff, L. W. Juergens, H. F. Scholz, H. B. Miner, Edwin B. Gute, C. D. Partridge, Fred A. Kretlow.

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Dr. E. L. Miloslavich addressed the annual meeting of the Wisconsin Chiefs of Police Association at Milwaukee, on October 7, 1931, on "Criminal Pathological Investigations". On November 6, 1931, the Doctor discussed the "Value of Post Mortem Examinations to the Practice of Medicine" at the meeting of the Manitowoc Medical Society, at the Holy Family Hospital, Manitowoc.

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Dr. R. H. Stiehm of the medical staff of the Wisconsin Anti-Tuberculosis Association, will leave Milwaukee on May 7 for Saranac Lake, N. Y., where he will take the four-week course on tuberculosis offered each year by the Trudeau Foundation. The course includes the latest information on the prevention, diagnosis and treatment of tuberculosis. Dr. Stiehm will return early in June.

BIRTHS

A daughter, Mary, to Dr. and Mrs. Ira R. Sisk, Madison, on April 15th.

A daughter to Dr. and Mrs. E. A. Pohle, Madison, on April 19th.

A son to Dr. and Mrs. Michael J. Kuhn, Milwaukee, on March 31st.

A daughter to Dr. and Mrs. J. P. Fetherston, Milwaukee, on March 5th.

A daughter, Sylvia, to Dr. and Mrs. Walter P. Tippet, Green Bay, on March 1, 1932.

DEATHS

Dr. W. G. Kemper, Manitowoc, died at Holy Family Hospital on April 8th. Death was due to complications following an infection.

He was born in Two Rivers, August 6, 1858, and studied medicine at Rush Medical College, graduating in 1882. He practiced at Chilton for a short time and later moved to Kewaunee and for five years practiced at Omaha, Nebraska, returning to Manitowoc county in 1889. Since that time, Dr. Kemper practiced in Manitowoc. For twenty years, Dr. Kemper served as county coroner. He also served one term as mayor of Manitowoc in 1903 and as city health officer for many years.

Dr. Kemper was a member of Manitowoc County Medical Society, the State Medical Society, and was a fellow of the American Medical Association.

He is survived by his widow and one son, Robert, a student at Lawrence College.

Dr. H. C. Maurer, Beloit, died on April 7th, of carbon monoxide poisoning.

Dr. Maurer was born in 1882 in Garnavillo, Iowa, where he received his early education. He taught school in Iowa for a few years before entering medical college. After graduating from State University of Iowa College of Medicine, he went to Beloit to begin the practice of medicine. During the World War he served as first lieutenant at a base hospital in Joselyn, Kansas, after which he returned to Beloit.

Dr. Maurer was a member of Rock County Medical Society, the State Medical Society, and the American Medical Association. He was a member of the staff of Beloit Municipal Hospital, and the Knights of Pythias.

He is survived by his widow.

Dr. J. C. Hayward, Marshfield, died at his home on April 11th, at the age of seventy-five years. Although he had been gradually losing strength for more than a year, he continued to hold his office hours regularly until a week before his death.

Dr. Hayward was born in Harrison township, Calumet county, September 27, 1857. He lived in Fond du Lac and attended high school there. Later he entered Chicago Medical College, now Northwestern University School of Medicine, receiving his degree in 1882. After a year of practice in

Fond du Lac, he came to Marshfield where he remained until his death.

On March 29th last, representatives of the State Board of Health, the Wood County Medical Society, the Ninth Councilor District, and old friends of Dr. Hayward in Marshfield joined with members of the Marshfield Clinic in paying tribute to Dr. Hayward at a banquet held at the Hotel Charles, Marshfield, in celebration of his fiftieth anniversary in the practice of medicine. Letters of congratulation were read from the following who were unable to attend: Dr. Otho Fiedler, President of the State Society; Dr. C. A. Harper, Madison, state health officer; Governor P. F. La Follette; Dr. K. W. Doege, Marshfield, who is in Europe, and Mr. J. G. Crownhart, Secretary of the State Society. As an expression of esteem, Dr. Hayward was presented with a purse of gold by the Wood County Medical Society.

Dr. Hayward took part in many civic affairs and was one of the founders of St. Joseph's Hospital. He served one term on the Wood County Board, and was a United States pension examiner for four years.

He was a member of the Wood County Medical Society, the State Medical Society, and was a fellow of the American Medical Association.

Dr. H. A. Fulton, Eau Claire, died on April 5th. He was born in Hudson in 1877 and was a graduate of Milwaukee Medical College in 1901. He practiced medicine in Eau Claire for thirty years.

Dr. Fulton was a former member of the Eau Claire & Associated Counties Medical Society, the State Medical Society, and the American Medical Association.

He is survived by his widow and one daughter.

Dr. John McK. Wyatt, Madison, died on April 11th, at a Madison hospital, at the age of eighty-three years.

Dr. Wyatt had been a practicing physician in Tennessee for more than fifty years and since 1925 had been living with his son in Madison. He was a graduate of University of Nashville Medical Department in 1878.

Dr. Patrick J. Taugher, 70, St. Nazianz, died on April 12th.

Dr. Taugher was born in the town of Meeme, November 27, 1861, and was a graduate of Northwestern University School of Medicine in 1883. He practiced in Manitowoc for one year, and St. Nazianz seven years, and then went to Wausau where he remained for nineteen years. He returned to St. Nazianz last June.

Dr. Taugher is survived by two daughters and three sons, one of whom is Dr. Victor J. Taugher of Milwaukee.

Dr. J. B. Brewer, Jefferson, died on April 13th at Shorewood hospital, Milwaukee.

Dr. Brewer was born in the year 1860 and was a graduate of Bennett Medical College of Eclectic Medicine and Surgery in 1893. At the time of his death, Dr. Brewer was Jefferson county physician and was a member of the State Board of Medical Examiners.

He is survived by his widow and one son, Dr. J. C. Brewer of Jefferson.

SOCIETY RECORDS

New Members

W. E. Allen, Albany.
R. C. Thompson, Cumberland.
C. A. Wood, 267 W. Main St., Waukesha.
Milton F. Stuessy, Blanchardville.
C. E. Baumle, Monroe.
H. L. Shapiro, Prairie du Chien.
Carl S. Harper, Jackson Clinic, Madison.
S. B. Pessin, St. Mary's Hospital, Madison.
C. C. Gascoigne, 609—58th St., Kenosha.
Leo Bleyer, Kenosha.
Ira F. Thompson, Racine.
W. J. Scollard, 606 W. Wisconsin Ave., Milwaukee.
Gordon J. Schulz, 1230 W. Grant St., Milwaukee.
L. C. J. Olsen, 2629 W. Greenfield Ave., Milwaukee.
B. I. Bender, 2303 N. Holton St., Milwaukee.
Nathan Goldberg, 238 W. Wisconsin Ave., Milwaukee.

Changes in Address

L. G. Weed, Phelps to 33½ So. Brown St., Rhinelander.
W. T. Austin, Fall Creek to Greenwood.
Carl W. Bradford, Hudson to 712 Townsend St., Lansing, Mich.
G. L. Baker, Rib Lake to Westby.

» » » CORRESPONDENCE « « «

SHALL CANCER BE REPORTED?

Editor, Wisconsin Medical Journal,
Madison, Wis.

Dear Mr. Crownhart:

There is quite a unanimity of opinion as to what to do for cancer patients when they get into the hospital. Admittedly these are mostly advanced cases. The problem that confronts the medical profession today is how to get the patient earlier. So far as we know and for present practical purposes cancer is a local disease, the removal of which, by mechanical or radiological means, usually insures a cure. The nearer the incipiency the greater the percentage of cures. The laboratory has done a work of great magnitude, but so far as curing the patient is concerned the results seem to be at a standstill, for cancer mortality is steadily climbing.

More than 100,000 die each year from this cause alone. So complacently do we view this situation that it suggests a lack of faith in our therapeutic resources. But this does not absolve us of our responsibility in the matter. We must turn our attention in other directions. I know the members of the medical profession well enough to know that it is only necessary to remind them of a duty to their patients to elicit hearty cooperation.

All of the statistics we now have on cancer are death reports. These cannot represent the situation in its true light. Cancer is a relatively slow disease, requiring about 3 years for it to complete its deadly work. So that instead of having 100,000 cases of cancer we have more like 300,000 people affected with cancer at one time among us. In other words, one person in four over 35 has a malignancy in some form. True all do not die of cancer. Many are cured and die of some other disease, or die of some other disease without being cured and in a very few spontaneous cure occurs.

Notification would show up the enormous number of cases, at present unknown to statisticians. Notification would prevent an incorrect record of a case of cancer and would also encourage early treatment. As the situation now exists many patients could not get early treatment owing largely to inadequate hospital facilities, but such deficiencies could be overcome by consistent education and pressure. Education can accomplish anything, in fact education is the only really compelling force. Notification and education have done much for tuberculosis, it can do more for cancer. Forty years ago the death rate from tuberculosis was four or five times that of cancer; today the cancer death rate is about one-third greater than that from tuberculosis.

Cancer should be made reportable to the Board of Health, as a foundation principle. In this way we could get a definite line on its incidence and topography and especially on its morbidity. Report every case of cancer, age and sex, nationality, community, location where originated, antecedents, environment, physical condition of patient, past and present, anatomical location, when symptoms were first noticed and when competent advice was first sought. WILLIAM E. GROUND.

Superior, Wisconsin,
March 30, 1932.

"INVALUABLE ASSISTANCE"

RYAN, SCHMIDT & RUDER
Attorneys at Law
First National Bank Building

Wausau, Wis., March 11th, 1932.

Mr. J. G. Crownhart,
Secretary of State Medical Society,
Madison, Wisconsin.
Dear Mr. Crownhart:

Thank you for the tax bulletin you so kindly sent to me in accordance with my request.

It is a very comprehensive and informative bulletin and should be of invaluable assistance to the doctor members of your organization in the preparation of their tax returns.

Yours very truly,
GEO. L. RUDER.

MEDICAL SECRETARIES

THE ROCHESTER PUBLIC SCHOOLS
Rochester, Minnesota

April 4, 1932.

Mr. J. G. Crownhart,
State Med. Society of Wis.,
119 E. Washington Ave.,
Madison, Wisconsin.
Dear Mr. Crownhart:

Have you ever wondered where a well-trained medical secretary could be secured? During the past few years the Rochester Junior College has specialized in this field. Our success in this training is such that all of our graduates who have been placed in clinics and hospitals thus far have kept their positions even in the face of the retrenchments of the past year.

Our course was organized after a careful study of the duties of medical secretaries. It is under the direction of an instructor who has had considerable experience as a secretary and editor of publications in various clinics. Students are carefully selected on the basis of scholarship and personal qualities.

The chief secretary to a famous surgeon said of our graduates, "I prefer them to four-year college graduates. They have less to learn and less to 'unlearn' when they get on the job."

We are graduating a small class in June of this year. If you have an opportunity of presenting this matter before your association we should appreciate it if you would announce to those members who anticipate a vacancy on their staff, that if they will write us we shall be glad to put them in touch with some member of the class.

Yours very truly,
ROY W. GODDARD, *Dean,*
Rochester Junior College.

RWG:PH

"CONTAIN THE INFORMATION"

April 18, 1932.

George Crownhart,
Secretary, State Medical Society,
119 East Washington Ave.,
Madison, Wisconsin.
Dear George:

I am writing to acknowledge your promptness and kindness in mailing me the pamphlets on Poor Relief Laws. I hardly knew that my letter was out of town before I had this response from you, and I appreciate it and thank you.

These pamphlets certainly contain the information so desired by so many municipal officers and by practicing physicians.

With very kindest regards to you, I am
Yours very truly,
W. H. ZWICKEY.

INTELLIGENCE OF THE CELL

To the Editor:

In a paper read before the Milwaukee County Medical Society about ten years ago I advanced the theory that the anatomic seat of the subjectively conscious ego is a single cell somewhere in the central nervous system. That theory was based on another theory: that individual cells have conscious intelligence. Comes now Dr. Carl Speidel, of the University of Virginia, with experimental evidence that cells do have intelligence.

What physician has not been intrigued with the fact that huge masses of cells may be removed from the body, in amputations and extirpations of organs, including even considerable areas of the brain itself, without subtracting anything from the ego of the individual. Of course, the metaphysicist can satisfy himself with some spiritual explanation, but the physicist must ask: where in the body is the physical basis for this ego? At least, he must conclude it cannot be resident in any of those parts, including large areas of the brain, which can be removed without any resultant diminution of the ego.

If cells have intelligence, as now experimentally adduced by Dr. Speidel (whether mechanistic or autogenetic is immaterial) it follows they have something akin to consciousness, and that predicates subjective consciousness and an ego. Therefore, we can conceive the living cells of the body as being endowed with consciousness (necessarily both subjective and objective) and an ego. As there can be no fusion of the ego of two or more separate beings, the ego of each living cell in the body must be a thing unto itself, separate from and nonfusible with the ego of every other cell. This opens the way to a cellular conception of the ego and consciousness, and to an explanation of many of their attributes on anatomical bases.

Long ago, in speculating over this problem, I conceived the idea that the physical basis of that which the individual conceives as his subjective consciousness and ego, is the subjective consciousness and ego not of any group of cells, but of a single cell so placed and correlated in the nervous system that the activities of all other cells within that system constitute its objective content. The spectacular work of Dr. Speidel lends experimental support to that viewpoint. Theoretically this cell should be in the mesencephalon, ontogenetically the oldest part of the brain.

J. J. SEELMAN.

205 E. Wisconsin Ave.
Milwaukee, Wisconsin.

"THE ISSUE IS PRACTICAL"

Crivitz, Wis., April 3, 1932.

Mr. J. G. Crownhart,
State Medical Society,
Madison, Wis.

Dear Sir:

Will it be possible for me to secure about forty copies of "Summary of Wisconsin Poor Relief Laws Affecting Care of Indigent Sick" for distribution to our county board members?

The issue is practical and answers a great many points with which the average office holder is not familiar. Thanking you, I am

Yours very truly,
L. E. NESS, *Chairman*
Marinette County Board.

Radiological Section Meets at Madison on Friday and Saturday, May 27th and 28th. State Society Members Invited

All members of the State Medical Society of Wisconsin are invited to be guests at the spring meeting of the Society's Radiological Section to be held at the Loraine Hotel, Madison, on Friday and Saturday, May 27th and 28th. The meeting opens at noon Friday and will continue through Saturday morning. The Friday evening meeting will be a joint session with the Dane County Medical Society. The program follows:

Friday, 1:30 P. M.

"The Radiological Diagnosis of Congenital Dislocation of the Hip"—S. A. Morton, M. D., Milwaukee.

"Pathology Revealed by Three Hundred Twenty-Five Roentgen Examinations of the Kidney, Ureter and Bladder Regions"—R. L. Troup, M. D., Green Bay.

"Roentgen Findings in Some Cases of Splenomegaly"—J. E. Habbe, M. D., Milwaukee.

"The Limitations of Intravenous Urography" (Lantern Slides)—H. W. Hefke, M. D., Milwaukee.

"Diverticula of the Stomach"—L. W. Paul, M. D., Madison.

Friday, 6:30 P. M.

Joint meeting with Dane County Medical Society.
Dinner.

"The Radiologist and the Medical Profession"—M. J. Hubeny, M. D., Chicago, Past-President, Radiological Society of North America.

"Symposium on Roentgen Diagnosis and Management of Bone Lesions" with three lanterns going simultaneously—Madison Radiologists.

Business meeting of Dane County Medical Society.

Saturday, 9:00 A. M.

Business meeting of the Section.

Round-table for presentation and discussion of interesting cases.

All physicians and surgeons are invited to participate in the sessions of the Section on Radiology.

Council Establishes Committee to Investigate Complaints of Members Relative to Admission to Wisconsin General Hospital

Creation of a special committee to investigate any complaint, specific in nature, arising out of admission of patients to the Wisconsin General Hospital during the calendar year of 1931 and 1932 to date, together with methods of admission, featured the Council meeting in Milwaukee on Saturday, April 23rd. Complaints must include name of patient and approximate date of admission and are to be forwarded direct to the Chairman of the committee, Dr. Reginald Jackson, Jackson Clinic, Madison. Cases admitted prior to Jan. 1, 1931, will not be investigated because of difficulty of ascertaining financial status prior to that date.

The Committee was established upon suggestion of Mr. J. G. Crownhart, Secretary, and its report is to be published in the July issue of the Wisconsin Medical Journal. Other members of the Committee are Drs. Frank W. Pope, Racine, and S. E. Gavin of Fond du Lac, with Dr. Gunnar Gundersen of La Crosse, ex-officio. The investigation will include present methods of admittance of patients in all classifications with recommendations. The complete minutes of the Council meeting follow:

MINUTES OF THE COUNCIL

Milwaukee, April 23, 1932

1. Roll Call. The Council was called to order by the Chairman, Dr. Arthur W. Rogers, Oconomowoc, at 9:20 A. M. Saturday, April 23rd, 1932, at the University Club, Milwaukee. Roll call showed the following present: Councilors Rogers, Redelings, Gavin, Smith, Stang, Blumenthal, Johnson, Pope, Cunningham and Beebe; President Fiedler, President-elect Jackson, Speaker Seeger, Chairman, W. D. Stovall of the Committee on Cancer and the Secretary, Mr. Crownhart.

2. Approval of Minutes. Moved by Smith–Gavin that the minutes of the January, 1932, meeting as printed in the Wisconsin Medical Journal of February, 1932, be approved. Carried.

3. Report of Auditors. Moved by Smith–Gavin that the reports of Pace, Gore and MacLaren, auditors for the Treasurer, and MacGowan and Taylor for Mr. Crownhart as Secretary and Managing Editor, be approved and placed on file at the Madison office open to inspection by any member, and that a summarized report of receipts and disbursements for the year 1931 be printed in the July, 1932, issue of the Wisconsin Medical Journal. Carried.

4. Membership. Report of membership by the Secretary was received. Moved by Blumenthal–Johnson that as respects collections for the balance of the present calendar year, the Secretary be authorized to accept divided payments, membership and medical defense to date from receipt of final payment. Carried.

5. Approval of Mail Ballots. Moved by Blumenthal–Gavin that the mail ballot be approved nominating Dr. J. V. Stevens of Janesville to Affiliate Fellowship in the American Medical Association. Carried. Moved by Gavin–Blumenthal that the mail ballot be approved accepting and authorizing publication of the proposed Standing Orders for Nurses in Industry. Carried.

6. Report of A. M. A. Delegates. The Committee on Scientific Work reports and recommends that the reports of delegates to the American Medical Association be consolidated into a single report before the general sessions with a time allotment of twenty minutes. After discussion it was moved by Gavin-Redelings that the report be accepted. Carried.

7. Membership of Dr. S. A. Morton. The Secretary conveyed the request of the Medical Society of Milwaukee County that Dr. S. A. Morton of Milwaukee be permitted to retain his membership in the Minnesota State Medical Association until 1934. Moved by Blumenthal–Redelings that the request be granted under conditions cited. Carried.

8. Wisconsin Anti-Tuberculosis Association. Pursuant to resolution of the Council of January, 1932, the Secretary laid before the Council copies of correspondence relating to the budgets of the Association. Moved by Stang–Blumenthal that the Secretary's report be laid on the table. Carried. Moved by Pope–Smith that the Chairman of the Council appoint a Committee of three to hold a joint meeting with officers of the Wisconsin Anti-Tuberculosis Association concerning budget and activities of the Association reporting to the September meeting of the Council. Carried.

9. Report of the Cancer Committee. Dr. W. D. Stovall presented the report of the Committee on Cancer, the Council voting on each item separately, after discussion, as follows:

A. Moved by Gavin–Smith that the Council authorize the appointment of a lay auxiliary committee by the Chairman of the State Medical Society's Committee on Cancer, the object of which committee shall be financial aid for such program as may be undertaken; appointments to be approved by the several members of the Committee and all subject to confirmation by the Council as well as all objectives of the Lay Auxiliary Committee. Carried.

B. Moved by Redelings–Stang that the State Medical Society Committee on Cancer shall see that committees are appointed in the County Medical Societies with duties to be outlined by the Committee on Cancer of the State Medical Society. Carried.

C. Moved by Smith–Stang that the Chairman of the State Medical Society Committee on Cancer outline a record system for hospitals and physicians receiving cancer patients which model records shall be made available after approval by the whole committee. Carried.

D. Moved by Cunningham–Smith that (1) the State Medical Society solicit the necessary funds from the Legislature to permit the State Laboratory of Hygiene to provide a central tumor registry; (2) that under the auspices of the State Medical Society Committee on Cancer there be arranged two meetings a year for physicians belonging to the registry, and (3) that when established the records and tissues at the tumor registry be open at all times to physicians only who may desire to use them for study. Carried.

E. Moved by Johnson–Redelings that the Council authorize publication of the State Survey as conducted by the American Society for the Control of Cancer in one issue of the Wisconsin Medical Journal. Carried.

F. Moved by Cunningham–Stang that, subject to Council approval, the State Medical Society Committee on Cancer be authorized to initiate their professional and lay educational program along the lines suggested in the cancer survey. Carried.

G. Moved by Johnson–Cunningham that the Chairman of the Cancer Committee of the State Medical Society be authorized to contact the State Board of Health for the purpose of making cancer a reportable disease under the following conditions:

(1) The cases to be reported direct, by name, without going through the local registrar.

(2) The Board to pledge secrecy of such records and to send no word or literature to the patients under any conditions or for any purpose.

(3) With the understanding that the purpose of this measure is as an additional means of securing essential data concerning this disease, and as a means of promoting interest and education among physicians generally.

10. Duties of the Secretary. The Secretary presented to the Council certain correspondence from members in which the Secretary was requested to forward information to all county societies for the purpose of securing instructed delegates on the questions involved. Moved by Cunningham–Pope that the Secretary submit to the Council for approval any such requests and that his correspondence with officers be limited to that arising out of his work as Secretary for the Society, the Council or the Committees of the Society or Council. Carried.

11. State of Wisconsin General Hospital. The Secretary presented a twenty page mimeographed report concerning several proposals made by members relative to admissions to the Wisconsin General Hospital, a state subsidy for local care, etc. After long discussion the Council recessed for lunch at 12:15 noon. Reconvening at 1:30 P. M. the Council heard the following recommendation of the Secretary: "The Council selects as a special committee Drs. Reginald Jackson, Madison, Chairman; Stephen E. Gavin, Fond du Lac, and Frank W. Pope, Racine, with Dr. Gunnar Gundersen, La Crosse, ex-officio, for the following purposes:

"A. To investigate any and all procedures of admittance of patients to the Wisconsin General Hospital;

"B. To request in the Wisconsin Medical Journal and to investigate any complaint from the general membership specific as to name and date during the calendar year of 1931 and 1932 to date pertaining to present methods of admittance of patients to the hospital, and

"C. To report its findings to the House of Delegates on present methods with recommendations".

Moved by Blumenthal–Stang that the resolution of the Secretary be accepted by the Council. Carried.

12. As Censors. The Secretary introduced several members of the Board of Censors of a component county society who were present in accordance with a request of the Council expressed at its January, 1932, meeting. The council heard in detail the statement of the member against whom charges had been filed, dismissed by the Board of Censors of the County Society, and then heard in detail the reports of each member of the Censors of the County Medical Society present. After discussion it was the concensus of opinion that the report of the Board of Censors of the County Medical Society be accepted after statement by the Chairman that the member concerned had, by his own actions, permitted an unfortunate incidence to occur which could not have been passed over by the Council and which must not occur within the Society in the future.

13. Automobile Accidents. The Secretary reported that the Committee on Public Policy had learned that less than 15% of the automobiles in Wisconsin were presently insured which low percentage made of little possible value any lien law for recovery of services rendered by hospitals, nurses and physicians in accidents arising out of the driving of automobiles. The Secretary distributed literature describing means used elsewhere to secure a better coverage and suggested that the Committee

on Public Policy would likely present recommendations at the September meeting.

14. District Meetings. At the request of the Secretary, Dr. Gavin described a meeting of presidents and secretaries of county medical societies in his district held recently for the purpose of furthering the aims of organized medicine within the district.

15. Responsibility of Secretary and Treasurer. The Secretary reported that the Secretary and Treasurer were individually responsible for Society funds in their possession and requested authority to secure bonds to protect such funds. Moved by Blumenthal–Pope that such authority be granted for the ensuing twelve months. Carried.

16. Fees for Accidents in Industry. Dr. Pope presented a letter sent by the Racine County Medical Society to a Compensation Insurance Company who requested physicians to sign an unreasonably low fee schedule. It was the concensus of opinion that the Secretary should call this subject to the attention of the County Society officers, in addition to the letter from his office of three months ago which was sent to the general membership.

17. Care of the Indigent. Dr. Stang discussed various aspects of the subject from the viewpoint of medical care. The Secretary reported that he had had requests for 3,000 copies of the publication of laws on the subject prepared by the State Medical Society. Dr. Johnson requested the Secretary to furnish Councilors with information on city hospitals.

18. Wisconsin General Hospital Committee. Moved by Sleyster–Blumenthal that the Special Committee created at this meeting of the Council be granted an appropriation of $500. Carried.

19. Instruction of Delegates. After long discussion it was moved by Blumenthal–Gavin that the President and Chairman of the Council write officers of the county medical societies suggesting that they defer instructing delegates on matters pertaining to the Wisconsin General Hospital and state subsidy for local care until the Special Committee made its report in the July Journal. Carried.

20. Care of Veterans. President Fiedler reported on the present status in Wisconsin of the proposals for local care of veterans with non-service connected disabilities.

21. Adjournment. Subject to call of the Chairman, the Council adjourned at 5:00 P. M.

Approved:

ARTHUR W. ROGERS, M. D.
Chairman of the Council.

J. G. CROWNHART,
Secretary.

THE AUDITS

The Council has inspected and placed on file the reports of Pace, Gore and MacLaren, auditors for the Treasurer, and MacGowan and Taylor, auditors for the Secretary and Managing Editor. These audits are on file at the offices of the Society and are open to inspection.

For general information the following condensed financial statements for the calendar year of 1931 are published:

STATE MEDICAL SOCIETY OF WISCONSIN

1931

RECEIPTS:

	General Fund	Medical Defense
Dues	$31,576.25	$2,470.00
Interest	1,281.97	290.00
Discounts	30.00	60.00
Miscellaneous	24.46	----
Total received during 1931	$33,127.61	$2,820.00

DISBURSEMENTS:

	General Fund	Medical Defense
Attorney's	--------	$955.99
Fees and expenses	--------	278.50
Salaries	$11,691.32	------
Rent	1,040.00	------
Supplies	3,032.48	------
Press Service	2,463.28	------
Travel	691.08	------
Cancer Committee	500.00	------
Wisconsin Medical Jour.	1,000.00	------
Meeting, net cost	1,441.01	------
Foundation Fund	225.00	------
Public Policy	2,224.08	------
Hygeia	466.76	------
A. M. A. Delegates	245.01	------
Secretaries' Conference	819.71	------
Legal	695.75	------
Committee expense	262.62	------
Treasurer	300.00	------
Total expense during 1931	$27,098.10	$1,234.49

The surplus of the Society was represented on December 31, 1931, by bonds whose face value was $25,000 in the general fund and bonds whose face value was $7,000 for the medical defense fund, with cash balances on hand of $773.18 in the general fund and $1,535.77 in the medical defense fund.

THE WISCONSIN MEDICAL JOURNAL

A Statement of Revenue and Expenses For Year Ended December 31, 1931

REVENUES:

Advertising Revenue	$9,157.09
Subscription Revenue	98.80
Interest Revenue	45.00
Miscellaneous Income	.50
Total Revenues	$9,301.39

EXPENSES:

Printing	$6,585.15
Salaries	1,740.00
Mailing	453.59
Cuts	414.00

Rent	300.00	Depreciation	9.80
Legal and Accounting	235.00		
Miscellaneous Expense	163.26	Total Expenses	$9,983.30
Supplies	20.90		
Discounts Allowed	25.80	Net Operating Loss on Publication	$681.91
Subscriptions	21.30		
Collection Expense	14.50	Balance December 31, 1931	$4,562.15

Postgraduate Course in Obstetrics and Gynecology Announced for Physicians in Southwestern Wisconsin

Postgraduate medical instruction, one of the Society's distinct contributions to the profession annually, will begin in June with a twelve weeks' course in Obstetrics and Gynecology for physicians in the southwestern counties. The instructors will be Dr. Otto H. Schwarz, St. Louis, Mo., and Dr. Everett D. Plass, Iowa City, both of whom conducted a similar course in eastern Wisconsin cities in the summer of 1931.

Dr. Otto H. Schwarz

Dr. Everett D. Plass

The centers for this year's course are as follows:

La Crosse
Tomah
Portage
Platteville
Richland Center
Monroe

The meetings in each center will be held on the same day each week for twelve weeks at the same time and place, beginning June 13.

The program again is sponsored by the State Medical Society, the University of Wisconsin Medical School, and the University Extension Division.

The class topics follow in the order of their presentation:

1. The Pelvis, Pelvimetry, and the Contracted Pelvis.
2. Ante Partum and Post Partum Hemorrhage: Causes, Diagnosis, and Treatment.
3. Obstetrical Analgesia and Anesthesia.
4. Forceps; Indications, Contraindications, Methods.
5. Management of Breech Presentations and Version.
6. Caesarean Section: Uses, Indications, and Abuses.
7. Management of Normal Pregnancy.
8. Complications of Pregnancy Including Abortion and Premature Labor.
9. Management of Normal Labor.
10. Management of Normal Puerperium.
11. The Toxemias of Pregnancy.
12. Puerperal Infections.

The classes will consist of informal lectures and demonstrations, in some of which lantern slides and motion pictures will be used. There will be opportunity in each class period for informal discussion of questions concerning obstetrical problems and related topics.

In Drs. Schwarz and Plass the Society has obtained two of the outstanding teachers of the subject; their extension experience has comprised years of teaching at similar centers in many states.

Dr. Schwarz is a graduate of Yale University and of Washington University School of Medicine. At the Washington University Hospital and Barnes Hospital in St. Louis he served successively as intern and resident physician, assistant and instructor in Obstetrics and Gynecology, associate in Obstetrics, associate professor of Obstetrics, professor of Obstetrics, and professor of Obstetrics and Gynecology.

He is affiliated with numerous professional societies and is the author of many articles in medical journals.

Dr. Plass was educated at Colgate University and Johns Hopkins University. He has been intern, assistant, and associate professor of Obstetrics at Johns Hopkins Medical School; assistant resident gynecologist at the Sloane Hospital for Women in New York City; obstetrician-in-chief at the Henry Ford Hospital, Detroit; and is now professor and head of the department of Obstetrics and Gynecology at the State University of Iowa. He is a member of many scientific societies and has contributed numerous papers on obstetrical problems. He is the author of "Obstetrics for Nurses" (Appleton, 1923).

The fee for the twelve weeks' course is $30. Application may be made to the University Extension Division, Room 108, Madison.

The course is under the management of the Medical Extension Advisory Committee, as follows:

For the State Medical Society of Wisconsin: Dr. Otho A. Fiedler, Sheboygan; Dr. G. Gundersen, La Crosse; Dr. J. F. Wilkinson, Oconomowoc; Dr. M. D. Bird, Marinette; Dr. K. H. Doege, Jr., Marshfield; Dr. A. J. Wiesender, Berlin; Mr. J. G. Crownhart, Madison. For the University of Wisconsin Medical School: Dean C. R. Bardeen, Dr. R. C. Buerki, Dr. J. S. Evans, Dr. John W. Harris. For the University Extension Division: Dean Chester D. Snell, Malcolm G. Little, Chester Allen, Nelson D. Conners, Benno W. Meyer.

A Challenging Issue*

By PAUL M. CURRER, M. D.
President
The Medical Society of Milwaukee County

Panel and contract practice has been the subject of so much discussion during the past few weeks that your President feels it incumbent upon him to state his views in this matter, as well as on some other phases of the medical situation.

As you all know, there has been more concerted and directed effort put forth by this Society in the last three or four years than ever before. All of the Society activities, under the guidance of the Board of Directors, officers, and committees, have been carried on, necessarily, at minimum cost because of the limited funds available. You, of course, are aware that at the present time only ten dollars of each senior membership dues and five dollars of each junior membership dues paid by you go to your County Society. We, therefore, have had to budget carefully and see to it that our expenditures are wisely and conservatively made.

Among our activities I might mention the effort which has been put forth in bringing about a better relationship between public health departments and county institutions with, we believe, beneficial results to both the public and the medical profession. The establishment and successful operation of the Physicians' Service Bureau and The Medical Business Bureau have been accomplished with no small amount of effort. More and better programs have been made available to our members through the efforts of various committees. Monthly programs, postgraduate courses, and economic meetings have been developed to a degree unknown to our members until the past few years. Through its educational work, using such mediums as the newspapers, the radio, a speakers' bureau, and by direct contact with lay organizations, the Society has endeavored to further establish the confidence of the public in the medical profession. Certainly this work is valuable for we cannot discount the value of public support in our efforts to solve medical problems.

I am sure that there is not a problem confronting medicine today which is not, or has not been, considered and acted upon where possible by officers and committees. You may rest assured that economic problems have not been ignored; they have been by far the most difficult to cope with as they are by no means local. When huge bodies such

* Presented before the Medical Society of Milwaukee County, April 8, 1932.

as the well-financed Committee on the Cost of Medical Care, after five years of study, cannot offer a definite, tangible solution, it should be readily recognized that with very limited funds our progress cannot be rapid. The lack of funds, however, is not the sole difficulty encountered in bringing about the desired results; the whole economic problem is so large and so complicated that it is quite apparent that it must be solved piece-meal.

This matter of contract and panel practice has been under discussion for a long time by your Board of Directors and committees. It has been recognized that nothing could be accomplished without facts. It is useless to talk about something of which you know actually nothing; by that I mean that facts are the only basis upon which any action, legal or otherwise, can be taken. Funds are required to obtain these facts, and for the first time these have been made available to your Society by the State Medical Society, through its Committee on the Distribution of Medical Service, for a study of contract and panel practice in Milwaukee County.

You, perhaps, do not realize the extent and variety of contract and panel practice. The Judicial Council of the American Medical Association has defined it in these words:

"By the term 'contract practice' as applied to medicine, is meant the carrying out of an agreement between a physician or group of physicians as principals or agents and a corporation, organization or individual, to furnish partial or full medical services to a group or class of individuals for a definite sum or for a fixed rate per capita."

Here are some types of practice in Milwaukee County which would come under this definition:

1. Medical departments, sponsored by industries and business organizations such as stores, restaurants, utilities, and a great number of other establishments.
2. Panels as required under The Wisconsin Workmen's Compensation Act.
3. City and government medical service, such as that rendered by expert witnesses in courts, school physicians, and county physicians.
4. Medical service sponsored by Mutual Benefit Associations and Lodges.

It is to be seen that we are dealing with no simple problem. We must remember, however, that contract practice in itself is not unethical.

"There are certain conditions which, when present, one or more of them, definitely determine a contract to be unfair or unethical. These may be stated as follows:

1. When the compensation received is inadequate, based on the usual fees paid for the same kind of service and class of people in the same community.
2. When the compensation is so low as to make it impossible for competent service to be rendered.
3. When there is underbidding by physicians in order to secure the contract.
4. When a reasonable degree of free choice of physicians is denied those cared for in a community in which other competent physicians are readily available.
5. When there is solicitation of patients directly or indirectly."

If any of these conditions are present we must produce facts which will prove our contention. I am sure that you will agree then that facts are essential; without them we are on unsafe ground.

PERSPECTIVE NEEDED

Another and very important phase of the situation is: what do our members wish to do when they have the facts? It is obvious that once the facts are known every member of the Society should be given the opportunity to express himself on this extremely-important subject. Without such expression on the part of each member no action in a general way would be wise, in my opinion, nor would it be to the best interests of the public and the medical profession of Milwaukee County.

While I, personally, am opposed to most forms of contract and panel practice, I believe that some forms cannot be done away with at the present time, regardless of our wishes. Also, I have a wholesome respect

for other opinions than mine, and I am aware that there is always the possibility that I may be wrong. For that reason, after careful consideration of facts presented, I am certain that the decision of the majority of our members will, undoubtedly, be right and will receive the approval of the public.

I do not feel that we are moving wisely when we take a stand collectively against concerns sponsoring medical services which we deem objectionable without having all the facts in advance of action. There is too much possibility of unfairness. If, in our deliberations, we come to the conclusion that a service is being sponsored by any business establishment, institution, or insurance company, which is unsatisfactory or unfair to the public and to the medical profession alike, let us consider it with the members of our Society. It is this type of contract practice which should and must be eliminated. Each one of our members has a responsibility to his profession and to organized medicine, which I am sure he will not ignore.

The fact-finding study which is getting under way immediately, and which should be completed in at least six months, is to be carried on in a friendly and impartial manner. There is no thought or wish to embark on this study in a critical way which, justly, would defeat our ends. For those who are in contract and panel practice,—and it is estimated that there are about 50%,—would resent any study except one made in an honest and impartial manner, and justly so.

Here it may be well to say that your officers feel their responsibility deeply. They recognize the difficulty of the times through which we are passing, and, if possible, would move mountains to improve the economic situation for our physicians. As it is, they will leave no stone unturned to improve the situation as much as possible. We have a good organization and one that is thoroughly representative of every section of our County.

In these times we are liable to lose our perspective. We must remember that conditions are abnormal,and chaotic conditions exist in nearly every field of activity today. We see in business and in industry a groping about in the dark. We, too, are at a loss to understand what it is all about. Under such circumstances it is easy to turn to any solution which sounds good, but in so doing there is real danger, for what we do now will largely determine medical practice of the immediate future.

We cannot accept a solution without calm consideration. It is certain that we cannot force any solution on the public, by political action or otherwise, which is not primarily in their interest. And here let me say: for a Society such as ours, representing every creed and every political faith, to participate in partisan politics would be fraught with serious consequences. This statement, however, should not be taken to mean that I believe we should not call to the attention of public officials such measures as we deem to be in the best interests of all or sponsor legislation which would benefit the public and the medical profession alike. In fact, I believe the opposite, but activity in behalf of political parties is another matter.

In conclusion, I cannot refrain from impressing upon you the importance of a united body. Nothing must be done to disturb this unity. There are very grave dangers ahead if we do so. With a divided group we will accomplish nothing. The foundation which has been so well laid for a greater Medical Society of Milwaukee County cannot be destroyed without seriously affecting the progress of the medical profession and the economic, social, and medical interests of the public.

I, as your President, therefore ask you to continue to give the same splendid support which you have so generously given in the past and you can be sure that your officers will strive in every way to justify your confidence. A president of a society with as many activities as ours must give a lot of time to his official duties, but I gladly give mine to the cause of medicine in the knowledge that I am doing my part, even though it be a small one.

Gentlemen, I wish to move the adoption by the Society of the following resolution:

WHEREAS, The general subject of corporate contract and panel medical practice is one of national scope, and

(Continued on page 356)

PRESS SERVICE OF STATE MEDICAL SOCIETY

No serum does so much for public health as printer's ink

PNEUMONIA

Madison, Wis.—March 17—Pneumonia is hand-and-glove with the flu epidemic of Wisconsin which is prevalent in many sections of the state at the present time. During 1930 pneumonia was the cause of 2,156 deaths in Wisconsin, and took its greatest toll among the young and those individuals beyond the age of 40.

The Educational Committee of the State Medical Society joined with the State Board of Health today in warning older people not to expose themselves to infection by visiting those where there is pneumonia and to take care of what may seem to be "just a cold."

"January, February, March and April are the four months in Wisconsin during which we generally experience our most sudden and extreme changes of temperature and our severest winter weather. April also brings its cold rains with many opportunities for securing wet feet," declares the State Medical Society bulletin issued today.

"We should not make a practice of staying indoors to avoid these sudden changes of temperature or extreme cold. If we are properly clothed, keep our feet dry, and do not carry our outdoor exercise to extremes, the exposure should help to build up our resistance against infections. We should come in from our outdoor exercise glowing with renewed vigor and with a healthy appetite.

"In meeting the demands of our appetite we should avoid too many sweets and eat plenty of green vegetables throughout the year. Moderation in everything should be our motto.

"The cultivation of regular health habits is of vital importance. Personal habits of cleanliness, such as washing the hands frequently and always before handling food, are essential to good health. We should make sure that we give our bodies the proper amount of rest after exercise. In fact, anything that will help build up our vitality and resistance will help protect us against disease in general.

"We should avoid exposing ourselves to infections by not visiting where there is pneumonia. Any disease that can cause over 2,000 Wisconsin deaths annually is of enough importance to warrant care of colds which frequently lead to pneumonia.

"Again, remember that this disease is no respecter of age, sex or station in life. It takes its toll wherever opportunity offers."

* * *

CANCER

Madison, Wis., Mar. 24—Competent authorities at present hold the opinion that cancers are caused, in a practical sense, by various irritations, to which the human body is exposed from the cradle to the grave.

The removal of these causes by reduction of sufferers is reducing the number of cancer victims, and where the causes are discovered early complete relief is afforded.

This official statement on the causes of cancer was issued by the Educational Committee of the State Medical Society today in order to point out to the public the situations under which cancer most easily develops. The statement declares that heredity can not be put down as a common cause of cancer. But irritations in different forms are the most frequent causes.

"Striking examples of this principle are numerous," continues the bulletin. "A cancer of the tongue or inside of the cheek, for instance, is often found directly opposite a jagged tooth. Cancer of the lip produced by the repeated irritations of a hot pipe stem is another common example. Cancer of the female genital organs is preceded in the majority of cases by some form of chronic inflammation. Tar, pitch, petroleum, soot, arsenic, dyestuffs, and a long list of similar irritants are responsible for the production of skin cancers.

"On the experimental side, cancer was successfully produced in the laboratory, in 1914, by two Japanese scientists who obtained this result by repeatedly applying coal tar to the skin of rabbits' ears. Many investigators have since confirmed their findings.

"Exactly how such irritation, or inflammation, operates to produce cancer or to favor its development, is the great question in cancer research today. For the average person, however, it is sufficient at present to know that some form of chronic irritation or chronic inflammation appears to play a most important part in the causation of all cancers.

"While it has not yet been proved that a person can directly inherit cancer, it does occur more frequently in some families than in others; and there is reason, therefore, to believe that members of such families are more likely to have this disease. A few forms of cancer show a distinct hereditary tendency, but others show no apparent hereditary trace whatever.

"Do not permit irritation or inflammations to become chronic. Such conditions favor the development of cancer."

* * *

DISEASE CARRIERS

Madison, Wis., Mar. 31—Men are often carriers of infectious diseases.

Typhoid fever may be carried by certain persons.

Tuberculosis may be carried by neglectful people.

Colds are spread by people.

Whooping cough and measles are carried by children, and even hoof and mouth diseases are carried by travelers.

"If people with diseases would be cautious, the rate of illness from infectious diseases could be reduced one-half in a single year," the Educational Committee of the State Medical Society announced today.

"Human beings themselves are frequently the carriers of disease. It is probable that many of the acute infectious diseases of childhood are directly conveyed from one child to another. Some individuals who have fully recovered from a disease may be carriers. There are others about to fall ill with a given disease, who are spreading disease germs, and then there is a group of habitual carriers in whose body the germ lives and thrives, and from whose bodies the germs are excreted for a considerable period of time. Typhoid fever may be carried in this way by certain individuals for many years. The same is true of persons with tuberculosis. An adult who is coughing and expectorating is suffering from what is called an open tuberculosis. He is a carrier who may spread the disease by the spray or droplet method and is a menace to other persons, especially to infants and young children.

"It has been said that public health is public wealth. If the extent of human disease can be limited, if human life can be prolonged, the world will be wealthier in that a great burden of sorrow will be removed and greater happiness promoted. Perhaps a

(Continued on page 352)

THE JOURNAL BOOK SHELF

Female Sex Hormonology. By William P. Graves, A. B., M. D. F. A. C. S., professor of gynecology at Harvard Medical School; surgeon-in-chief to the Free Hospital for Women and to the Parkway Hospital, Brookline, Massachusetts. 131 pages, with illustrations. Cloth, $3.50. W. B. Saunders Company, Philadelphia.

Living the Liver Diet. By Elmer A. Miner, M. D., Independence, Kansas. With introduction by William P. Murphy, M. D., instructor in medicine at Harvard Medical School, Boston. Price $1.50. C. V. Mosby Company, St. Louis, Mo. 1931.

Surgical Pathology of the Disease of Bone. By Arthur E. Hertzler, M. D. In the preface to this book the author states, "There is not, to my knowledge, any book which treats in a comprehensive manner the pathology of the disease of bones. That there is need for such a book is apparent to every teacher of surgery. The only excuse I have to offer for the publishing of such a book is that no one more capable has made any attempt to fill this very obvious need".

Infections of the Kidney. By Meredith F. Campbell, M. D., F. A. C. S., Price $3.00. Harper & Brothers, Publishers, 49 East 33rd St., New York.

A Textbook of Clinical Neurology. By Israel S. Wechsler, M. D., professor of clinical neurology, Columbia University, New York; attending neurologist, Neurological Institute and The Montefiore hospital, New York. Second edition, revised. Cloth, $7.00 net. W. B. Saunders Co., Philadelphia, 1931.

The Human Voice, Its Care and Development. Leon Felderman, M. D., price $2.50. Henry Holt & Company, One Park Avenue, New York City.

A Doctor of the 1870's and 80's. By William Allen Pusey, sometime president of the American Medical Association and of the American Dermatological Association. Charles C. Thomas, Publisher, Springfield, Ill. 1932.

Varicose Veins. With special reference to the injection treatment. By H. O. McPheeters, M. D., F. A. C. S., director of the Varicose Vein and Ulcer Clinic, Minneapolis General Hospital; attending physician New Asbury, Fairview and Northwestern Hospitals, Minneapolis. Illustrated with 62 halftone and line engravings. Third revised and enlarged edition. Price $4.00. F. A. Davis Company, 1914 Cherry Street, Philadelphia, Pa.

Primer On Fractures. By Cooperative Committee on Fractures, American Medical Association. Second Edition.

Surgical Pathology of the Skin, Fascia, Muscles, Tendons, Blood and Lymph Vessels. By Arthur E. Hertzler, M. D., surgeon to the Agnes Hertzler Memorial Hospital, Halstead, Kansas, professor of surgery, University of Kansas. 260 illustrations. J. P. Lippincott, Company, Philadelphia.

Psychology and Psychiatry in Pediatrics. The problem report of the subcommittee on psychology and psychiatry, Bronson Crothers, M. D., chairman. White House Conference on Child Health and Protection. Price $1.50. The Century Co., New York.

Body Mechanics: Education And Practice. Report of the subcommittee on orthopedics and body mechanics. Robert B. Osgood, M. D., Chairman. White House Conference on Child Health and Protection. Price $1.50. The Century Company, New York, New York.

Physicians Manual of Birth Control. By Antoinette F. Konikow, M. D., 1931, The Buchholz Publishing Co., 1501 Broadway, New York City.

History of Medicine in the United States. By Francis R. Packard, M. D., Editor, Annals of Medical History. In two volumes. Paul B. Hoeber, Inc., New York. Price, $12.00.

Gynecology and Urology for Nurses. By Samuel S. Rosenfeld, M. D., F. A. C. S. Adjunct obstetrician and gynecologist Lebanon Hospital, New York City; lecturer in obstetrics and gynecology to Lebanon Hospital School for Nurses; diplomate of the American Board of Obstetrics and Gynecology. Price $2.00 net. William Wood and Company, New York. 1931.

A Non-Surgical Consideration of Prostatic Enlargement. Including a lecture on the myth of the bladder neck bar. By Edwin W. Hirsch, M. D., associate in urology, College of Medicine, University of Illinois; urologist, Englewood Hospital, Chicago; member, American Urological Association, Chicago Urological Society, and American Medical Association. Price $2.00. Bruce Publishing Company, Minneapolis and St Paul, 1931.

Emergency Surgery. By John William Sluss, A. M., M. D., F. A. C. S., Associate professor of surgery, Indiana University School of Medicine, zone surgeon, United States Fidelity and Guaranty Company; consulting surgeon, City Hospital, and John Walter Martin, M. D., assisted by David Hart Sluss, M. D., and Camilius B. DeMotte, M. D. Fifth edition, revised and enlarged. 797 illustrations, some in colors. Price $5.00. P. Blakiston's Son & Co., 1012 Walnut St., Philadelphia.

BOOKS RECEIVED FOR REVIEW

Biochemistry in Internal Medicine. By Max Trumper, Ph.D., clinical chemist and toxicologist; formerly in charge of the Laboratories of Biochemistry of the Jefferson Medical College and Hospital and of the Psycho-Biochemistry Laboratory, Graduate School of Medicine, University of Pennsylvania, and Abraham Cantarow, M.D., instructor in medicine, Jefferson Medical College; assistant attending physician, Philadelphia General Hospital; in charge of Laboratory of Biochemistry, Jefferson Hospital. 454 pages with illustrations. Philadelphia and London: W. B. Saunders Company, 1932. Cloth, $5.50 net.

Psyllium Seed: The Latest Laxative. By Dr. J. F. Montague, medical director, Montague Hospital for intestinal ailments; late of University and Bellevue Hospital Medical College; fellow American Medical Association; fellow New York Academy of Sciences; fellow New York Pathological Society; sometime fellow New York Academy of Medicine and American College of Surgeons. 20 illustrations. Montague Hospital for Intestinal Ailments, New York City. 1932.

Pathology For Nurses. By Eugene C. Piette, M.D., pathologist and director of the Clinical Laboratories of the West Suburban Hospital, Oak Park, Illinois: Consultant Pathologist, Chicago State Hospital. With 65 illustrations, some in color. Price $1.75. F. A. Davis Company, 1914 Cherry St., Philadelphia, Pa.

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5. **Correlation** - the relationship of food constituents to one another is the same as in breast milk.
6. **Other Physical Characteristics** - Caloric value, pH, depression of freezing point, electrical conductivity, are the same as breast milk.
7. **Buffer Curve** - varies within the same limits as breast milk.
8. **Digestibility** - gastric emptying time is the same as breast milk.
9. **Stools** - similar in color, odor, and consistency to breast milk, and the bacterial flora is predominantly acidophile.
10. **Vitamin A** - regarded by many as the anti-infective vitamin, is present in S.M.A. in adequate amounts.
11. **Uniformity** - Composition of S.M.A. is always the same wherever fed.
12. **Keeping Quality** - S.M.A. keeps and is safe to feed in any climate.
13. **Simplicity** - no complicated formula to harass the busy physician and confuse the mother.
14. **No Modification** - for more than 90% of well infants, S.M.A. requires no modification, although S.M.A. is very flexible.

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Please send me without obligation:
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- ☐ More details on similarity to Breast Milk. 51-52

Modern General Anesthesia. By James G. Poe, M.D., lecturer on general anesthesia in the Medical and Dental Departments of Baylor University; anesthesiologist of Baylor University Hospital of Dallas; consulting anesthetist to the Shriners' Hospital for Crippled Children, and Parkland Hospital, Dallas, Texas. Second edition, completely revised and enlarged. With 12 illustrations and 2 charts. Price $2.50. F. A. Davis Co., 1914 Cherry St., Philadelphia, Pa.

Obstetric Education. Report of the subcommittee on obstetric teaching and education, Fred Lyman Adair, M.D., Chairman. White House Conference on Child Health and Protection. Price $3.00. The Century Co., New York.

Nutrition Service in the Field. Report of the subcommittee on nutrition. Lucy H. Gillett, Chairman. White House Conference on child health and protection. Price $2.00. The Century Co., New York.

Growth and Development of the Child. Part III. Nutrition. Report of the Committee on Growth and Development Kenneth D. Blackfan, M.D., Chairman. White House Conference on Child Health and Protection. The Century Co., New York. Price $4.00.

BOOK REVIEWS

Any scientific publication reviewed in this column may be obtained for inspection. Orders for such inspection should be directed to the Medical Library Service, 424 N. Charter Street, Madison, Wis.

Clinical Roentgen Pathology of Thoracic Lesions. By William H. Meyer, M. D., professor of roentgenology in the New York Post-Graduate Medical School of Columbia University. Director of roentgenology in the New York Post-Graduate Hospital. Illustrated with 183 engravings. Price $6.00 net. Lea & Febiger, Philadelphia.

The author has given post-graduate instructions in roentgenology for many years. In order to provide his pupils with a suitable text to accompany the lectures, he presents this book as a first volume in a series of similar essays to come. Following a brief introductory chapter dealing with the fundamental considerations of roentgen interpretation the subject matter is dealt with in six sections as follows: the roentgenological study of the thorax, roentgen pathology, diseases affecting the thoracic cage, special diseases of the respiratory system, lesions of the heart and pericardium and the esophagus and subphrenic organs in relation to intrathoracic pathology. Due to the limited amount of space only the important points are discussed; references to the literature have also been omitted. This gives the book a very personal note. The large number of illustrations render the study of the text attractive; particularly the schematic sketches presented in the fashion of "blackboard drawings" bring out clearly the important pathological changes. Last but not least deserves mention a very helpful alphabetical cross index.

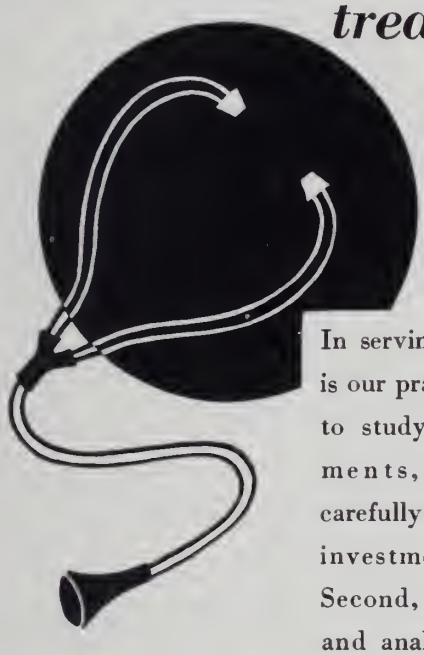
There is no doubt that the medical student during his senior year and, of course, likewise the physicians studying roentgenology as a specialty, will find it worth while to read Meyer's book. Before entering this field of endeavor, both should read twice the author's confession—"That part of roentgenology that has to do with the translation of shadow values into terms of pathology is an art no better or worse than many other branches of medicine, dependent mainly upon inborn ability, with a well-rounded knowledge of general medicine, thorough training and long-continued accumulating experience. The part of roentgenology that deals with physiotechnical matters is truly a science as nearly accurate as any of the higher sciences. Especially in the interpretation of intrathoracic lesions are the applied factors of ray divergence in relation to posture, gravitational changes, hydrostatic principles and aerodynamics adaptable." E. A. P.

Electrotherapy And The Elements Of Light Therapy. By Richard Kovacs, M. D., clinical professor and director of physical therapy, Polyclinic Medical School and Hospital, New York; visiting physiotherapist, Manhattan and Harlem Valley State Hospitals and West Side Hospital; Consulting physiotherapist, Hackensack Hospital and Mary Immaculate Hospital, Jamaica, New York. Price $6.50. Illustrated with 211 engravings. Lea & Febiger, Philadelphia, 1932.

This book has grown out of the courses of instruction in physical therapy which the author has held for many years in New York City. He justly emphasizes in the beginning that a thorough knowledge of physics is the indispensable basis for anyone who wishes to enter the field of physical therapy as a physician and practice it successfully. The entire first part is, therefore, devoted to the fundamentals of electricity. The second part deals with general electrotherapy and electrodiagnosis and contains chapters on therapeutic currents—comparative physics and principal effects; therapeutic currents—conduction through the body; electrodes and other accessories; the galvanic current—physics and effects; the galvanic current—therapeutic uses; surging and interrupted currents of low tension and low frequency; electrodiagnosis—theory and technique; electrodiagnosis in pathologic conditions; currents of low tension and low frequency—therapeutic uses; high-frequency currents—physics; high-frequency currents—physical and physiological effects; medical diathermy; technique of regional diathermy; surgical diathermy; the static current—physics; the static modalities—clinical uses; prescribing and administering electrotherapy and electrical accidents. In the third part the author discusses the elements of light therapy under the headings of physics of radiant energy; photothermal radiation; photochemical radiations—physics and effects and photochemical radiation—clinical uses. The fourth part is devoted to applied electrotherapy and has been subdivided in electrotherapy in diseases of the central nervous system; electrotherapy in affections of the

DIAGNOSIS

determines the treatment



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peripheral nerves; electrotherapy in traumatic conditions; electrotherapy in arthritis and rheumatoid conditions; electrotherapy in diseases of the respiratory and circulatory systems; electrotherapy in diseases of the gastro-intestinal system; electrotherapy in gynecology and electrotherapy in genito-urinary diseases of the male. The next chapter discussing the use of electricity in dermatology has been written by J. J. Eller (New York) and the following dealing with electrotherapy in diseases of the ear, nose and throat has been contributed by W. Morrison (New York). Physical therapy in institutional practice outlining problems as to organization and personnel, location, floor space, equipment and records has also been given space. To most subdisions of the book a brief bibliography has been appended. A helpful guide for the novice is the last section called "Electrical Glossary". In alphabetical order it gives brief explanations of the more common terms used in electrotherapy.

The critical reader will find much valuable information in Kovac's textbook and if one may not always agree with the author's viewpoint it must be remembered that physical therapy is a comparatively young field only recently recognized as a specialty, which is rapidly being developed on a sound, scientific basis. E. A. P.

MEDICAL LIBRARY SERVICE

During the economic depression, public libraries report a very considerable increase in their book circulation. In a period of enforced leisure, thinking people find a breathing spell to recoup their scattered energies, and take thought for the future.

Physicians, feeling the pinch of the times at least as much as any other class, may well look to their professional advancement. Medical literature is voluminous, but a few well-chosen volumes from the Medical Library in your state may solve the very problem which perplexes you, or serve to clarify an idea but dimly realized.

A doctor from one of the smaller clinics in the state in commenting on some literature sent to him says, "I have received the three books that you sent me, and thank you so much for them. They are good books, and there is so much interesting data that I simply cannot get it all in two weeks. May I keep them for two more weeks please?" Another letter in acknowledging references on intestinal obstruction says, "I am very grateful for the promptness and quality of your medical service."

Perhaps due to the depression you have had to discontinue some of your medical periodicals. The Medical Library Service loans journals as well as books at the cost of wrapping and postage, and you may keep up in your reading with the latest advances in medical science.

Address your requests to the Medical Library Service, S. M. I. Building, University of Wisconsin, Madison.

PRESS SERVICE

(Continued from page 347)

few of us appreciate the great debt of gratitude which is due to those workers who have sacrificed everything, in some instances even life itself, to promote a science which has for its object the relief of human suffering, the prolongation of life and the prevention of death.

"Perhaps more important than the cure of the disease is its prevention. This is best illustrated by the case of smallpox. The time was when nearly every human being contracted smallpox and many of them died. The disease was particularly prevalent among infants and young children. Contending armies suffered higher mortality from smallpox than from onslaught of their adversaries. This was all changed by the discovery of vaccination by Jenner in 1798. Smallpox is a preventable disease and its occurrence is a disgrace and a reflection on the intelligence and the sanitary status of a community. In connection with the discovery of the toxin of the diphtheria it has been learned that the administration of a minute dose of the so-called 'toxin-antitoxin' will prevent diphtheria. Scarlet fever can be prevented in the same way."

* * *

COOKING PORK

Madison, Wis., Apr. 7—Brown pork chops in a pan, cook heavy chunks of meat with sauerkraut, but never eat sausage made of raw meat.

Pork, well cooked, is a nourishing food, but there are dangers immeasurable in eating pork not well done. There is a little germ in pork called Trichina. Heat destroys that germ.

"If pork were always well cooked, there would never be a case of trichinosis," declares the Educational Committee of the State Medical Society in a bulletin out today. "The fact that now and then the disease develops and many cases have occurred in Wisconsin during the winter indicates people do not understand the dangers.

"The disease caused is rather dangerous. Its mortality is usually below that of typhoid fever, with which its symptoms are somewhat identical; which is about the only cheerful thought possible to the fellow who has it. He can also, while thinking about it, reproach himself with the knowledge that he need not have suffered the attack, for he certainly, and unwisely, ate some raw or uncooked infested pork.

"Authorities tell us that something like two per cent of all hogs are infested. Two per cent are in such condition as to be dangerous to human life and health, if the meat were eaten raw. Most of our people, unlike some people of European countries, do not eat uncooked meat. Within the past few months, however, two widely separated epidemics did occur in one state, both caused by the eating of infested sausage that had not been cooked.

"The first of these epidemics occurred in a Pennsylvania college for young men, one of whom received a quantity of sausage as a gift from an acquaintance. It was eaten without further cooking by this young man and six of his friends, and all of them developed typical cases of trichinosis within a week. They were all very sick and one of them died.

"With all this there is no valid reason why pork and its products should not be included in one's diet list. Properly cooked, it may be eaten without fear, but it must be thoroughly cooked, until all red color has disappeared in the centre of the piece, as well as on the surface."

* * *

COD LIVER OIL

Madison, Wis., Apr. 14—Cod liver oil is not a luxury but an indispensable food for young children. The Health Bulletin of the State Medical Society is-

"Deeds, Not Words"

HOW MEAD JOHNSON & COMPANY, MAKERS OF INFANT DIET MATERIALS* ASSIST IN KEEPING PEDIATRIC CASES IN MEDICAL HANDS

YOUR BABY AND YOUR DOCTOR

Periodic examination of your growing child by your physician is not only of immediate benefit, but preserves physical fitness by preventing the development of diseases which damage progressively with the passing years. In the end, it also saves money.

VITAMIN EXPLOITATION

Vitamins are being over-exploited through newspaper, magazine and radio advertising. Practically every known vitamin is present in a well-balanced diet of ordinary foodstuffs. For reliable economical advice on vitamins, consult your physician rather than commercial interests.

NOT ALL BABIES ARE ALIKE

Your baby's feeding problems are different from those of other babies, and in fact vary at different times. Your physician is the only qualified adviser in these matters which vitally affect your baby's health and future.

All Mead Products are advertised only to physicians, without dosage directions, or selling "literature" accompanying packages.

HELPING TO KEEP INFANT FEEDING IN MEDICAL HANDS

EVERY day, many thousands of printed slips like these here illustrated are distributed in all packages of Mead's Infant Diet Materials and are read by mothers and fathers in every community and in all stations of life. There is no ulterior motive in this effort to educate laymen on the importance of medical advice, as no reference is made to Mead products or their use. This is only one of the practical ways by which we live our creed: infant feeding and vitamin therapy properly belong in the hands of the medical profession.

*MEAD'S VIOSTEROL, MEAD'S STANDARDIZED COD LIVER OIL, MEAD'S CEREAL, MEAD'S DEXTRI-MALTOSE NOS. 1, 2 AND 3, MEAD'S DEXTRI-MALTOSE WITH VITAMIN B

Mead Johnson & Company, Evansville, Indiana, U.S.A.

sued today declares that cod liver oil should be included in the diet of children under two years of age, and should be given to all young children under proper direction, especially when malnutrition is present.

Declaring that when economic stress exists care should be exercised in the selection of foods for children, the bulletin declares that "there is even greater need for cod liver oil."

"At least three or four vegetables and one fruit daily are usually considered advisable in an adequate diet for children or adults," continues the bulletin. "In emergency-relief planning, however, it is not always possible to provide vegetables or fruit to this extent or variety. Diets for both children and adults can and must be planned to include at least one vegetable or fruit daily (preferably two) in order to provide minerals and vitamins. In both these respects vegetables give better returns for the money than fruits.

"Whole milk (unskimmed) should be the foundation of every diet. It is imperative in the diet of every child throughout the whole period of growth and in the diet of every pregnant and nursing mother. In every food-relief plan effort should be made to allow enough money to provide one and one-half pints to one quart of milk daily for every child and every pregnant or nursing mother, and half this amount for each other adult. When, however, in budgeting emergency relief, funds are so limited that this is not possible, at least one pint for every child and every pregnant or nursing mother must be provided daily. For the baby who must be fed artificially the full amount of milk required in his daily formula should always be allowed. Though milk may seem to be an expensive food, money spent for milk will bring a better return in food value than money spent for any other food."

The Medical Society declares that a dollar for food should be divided as follows: 25 cents for vegetables; 25 cents for fats and sugars; 25 cents for cereals, bread and beans; 25 cents for other foods.

"But the results of prolonged general underfeeding, commonly known as 'general malnutrition,' while they may be less dramatic and more easily overlooked, are not less serious," concludes the bulletin. "In time of economic stress children may suffer both types of damage unless the diet is carefully safeguarded."

* * *

INFECTED TEETH

Madison, Wis., Apr. 21.—Teeth that were filled or crowned in the last fifteen years in many cases have become the source of infection resulting in rheumatism, the State Medical Society of Wisconsin declares in its weekly bulletin today.

"If you are ailing in health and have any crowned teeth or even molars that have been filled, have them x-rayed at once," advises the medical bulletin. "Focal infection is believed to be the cause of many of our ills. Focal infection, as far as the teeth are concerned, is usually manifested by abscesses or pus pockets on or around the roots. Ordinarily these do not occur in healthy teeth, commonly appearing when the nerve has been destroyed by infection or intentionally, and the tooth becomes devitalized.

"Is this condition new, and if not why were these abscesses and the possible resulting danger not recognized until comparatively recently? Before the development of so-called modern dentistry, the majority of decayed teeth were extracted. Later it was thought that all teeth should be preserved as long as possible. Then came the era of gold and porcelain crowns put on over roots whose nerve canals were filled, and the elaborate inlays and fillings also in dead teeth. Then the x-ray changed the picture. It became possible in most cases to recognize in the film these pus roots and it was noticed that they more often occurred on or around the dead teeth.

About the same time two renowned physicians, Doctors Billings and Rosenow, began to advance the idea that many diseased conditions were directly traceable to localized infection somewhere in the body, frequently in the tonsils and sinuses. Another physician who is also a dentist, Dr. Frederick Moorehead, was called to assist them in their work. With the assistance of the x-ray their investigations proved beyond all doubt that abscessed teeth are among the greatest offenders of the focal infection group. The part played in the cause of disease by these infections has been so well established that few physicians doubt the importance of the early recognition and removal, if possible, of all foci of infection in the well as in the sick.

"The doctor searches for such infections in the various diseases of the heart, blood vessels, and kidneys, particularly in those cases showing 'high blood pressure,' even though there may have been other antecedent causative conditions. Focal infections play a part in diseased conditions of the thyroid, notably exophthalmic goitre and toxic adenoma. When the patient complains of 'rheumatism,' which may be a neuritis, or inflammation of nerve coverings; arthritis, inflamed joints; or myositis, inflamed muscle;—the teeth are among the first things to be investigated even in the young individual. Not rarely do abscesses form on teeth not devitalized, frequently due to pressure from the adjacent teeth. Frequently almost miraculous relief from pain follows the extraction of such diseased teeth. Many obstinate headaches are similarly cured. Often defective vision, dizziness, and impairment in hearing are relieved. Sufferers from asthma may be sensitive to the protein of the bacteria from their own focal infections. Ulcers of the stomach and duodenum probably occur as frequently from pus sacs on or around the teeth as from diseased tonsils and sinuses. The same is likely true of gall bladder infections, and these, themselves, often are centers of other more remote infections."

* * *

PYORRHEA

Madison, Wis., April 28.—Preventive measures will do more to cure pyorrhea of the mouth than all the drugs and solutions that may be used thereafter. So long as people's teeth are clean below and above the gum line, the bleeding places of the disease will be wiped out.

"Pyorrhea is one of the most common diseases among children and adults," declares the Educational Committee of the State Medical Society in a bulletin issued today. It declares that the exercise of caution in the cleaning of the teeth during childhood will go far to prevent destruction of the teeth by pyorrhea in later life.

"If taken in its early stages, pyorrhea is a preventable disease," continues the bulletin, "but if allowed to progress without proper measures of control it always results in loss of the teeth. Not all inflammatory conditions of the gums can be classed as pyorrhea. Only when irritations are permitted to exist unmolested and infection sets in, with pus forming in the gums about the teeth, does it become true pyorrhea. This condition may be brought about in two ways—first, by personal carelessness in allowing masses of tartar and food debris to accumulate on the teeth, thereby affording fertile soil for the growth of pus forming bacteria, which rapidly destroy, not only the soft gum tissue but the bony socket in which the tooth is held, as well.

"In this type of case, prevention is easily established and maintained by careful and regular cleaning at the hands of a competent dentist, with full cooperation in the mouth cleansing by the individual to remove the hard deposits of tartar himself, therefore proper teamwork with the dentist is absolutely necessary. Proper care in the early stages of cases of this kind is almost sure to keep it entirely under control.

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"In the second class of cases there is almost always some systemic disorder which plays an important part in establishing the disease. This type of case does not yield so readily to treatment. It is known that certain diseases such as tuberculosis, diabetes and malnutrition are often accompanied by this most stubborn type of pyorrhea. It may be necessary to have a complete physical examination by a competent physician to discover the underlying cause. Often times, such cases may be greatly helped by certain simple changes in diet.

"There is no mouth wash, tooth paste, lotion or medicament of any kind that will cure pyorrhea. No drug can be used in the mouth in strong enough solution to be of more than momentary value in combating bacteria. It is necessary first to completely clean the surfaces of the teeth above and below the gum line by the family dentist in order to destroy the breeding places for the bacteria that cause the destruction of these tissues."

CHALLENGING ISSUE

(Continued from page 346)

WHEREAS, It has grown to involve a very large number of our profession nationally as well as locally, and

WHEREAS, The general effect appears to be inimical to the best interests of the American public by setting apart a class of people whose medical services are procured more cheaply at the expense of the rank and file of American citizens, and

WHEREAS, It has ever been true that the American Medical Association has as its first and most important interest the health of the citizenry of America,

Be it hereby resolved, That The Medical Society of Milwaukee County goes on record and hereby directs its officers to bring promptly and forcefully to its parent organizations, the State Medical Society of Wisconsin and the American Medical Association, its belief and desire that the corporate and contract practice of medicine should at once be given thorough study and careful consideration to the end that all that is unfair, unethical, and inimical to the best interests of the public be promptly and permanently eliminated, and

WHEREAS, It is the belief of The Medical Society of Milwaukee County that certain of its members are at present parties to a contract of a type in which both by intent and effect a type of medical service is being rendered which is inadequate and unfair to the beneficiaries and beneath the dignity and level of honesty of our profession, and

WHEREAS, This prostitution of medical practice in Milwaukee County intereferes with reasonable competition among physicians and is, therefore, inimical to the interests of the profession and public alike,

Be it further resolved, That The Medical Society of Milwaukee County hereby goes on record and instructs its Board of Directors to act under Section I of Chapter II of the Constitution and By-Laws of The Medical Society of Milwaukee County and expel any and all of its members who, contrary to Article VI, Section II, of the Principles of Medical Ethics of the American Medical Association, have contracts, implied or written, which demand of them a service, the quality of which is beneath the standards of our profession, and any and all members whose contracts, implied or written, demand of them the rendering of medical or surgical services to financially-responsible citizens on a fee basis so below the normal standard of medical and surgical fees as to interfere with the rendering of adequate service to the public and reasonable competition among the physicians of our community.

EDITOR'S NOTE: The resolution was immediately adopted.

COOK COUNTY SUMMER CLINICS

The regular Summer Clinics given by the staff of Cook County Hospital under the auspices of the Chicago Medical Society will be held during the weeks of June 6th to June 18th, inclusive.

As customary in time past, the usual $10.00 registration fee will be charged to cover the expense of organization.

These Clinics will be held during the time of the graduation exercises of the medical schools and will be a most convenient time for medical men to participate in the special activities of Alumni Week and also to attend the Postgraduate Clinics at Cook County Hospital.

The Staff of Cook County Hospital and the Alumni organizations are each presenting independent programs that should be of interest to visiting physicians.

Applicants desiring to enroll for the postgraduate Clinics should make application as soon as possible to the Secretary of the Cook County Summer Clinics, care of the Chicago Medical Society, 185 North Wabash Avenue.

INSURANCE BY OCULISTS

With the advent of insurance against the loss or breakage of eye glasses, members of the Society are advised that they may act as agents for such insurance companies provided that they receive no commission or compensation whatsoever for accepting the application from their patients for such insurance. This was the statement made by H. J. Mortensen, Commissioner of Insurance of Wisconsin, in response to a recent inquiry from a member of the State Society.

Mr. Mortensen points out that if a physician should receive a commission or compensation for writing such insurance he would be acting as an insurance agent, and under the state laws insurance agents must be licensed. The licensing provision can be avoided, however, if the physician receives no compensation for the writing of this insurance.

PHYSICIANS' EXCHANGE

Advertisements for this column must be received by the 25th of the month preceding month of issue. A charge is made of $2.00 for the first appearance of copy occupying 1 inch or less of space and $1.00 for each succeeding insertion of the same copy. Kindly accompany copy with remittance to cover number of insertions desired. Advertisements from members of the State Medical Society will be accepted without charge. Such copy will be taken out after its second publication unless otherwise requested. Where numbers follow advertisements replies should be addressed care Wisconsin Medical Journal.

WANTED—Surgeon with 16 years experience, 4 years postgraduate work in Europe, desires group appointment or association with busy surgeon or general practitioner. Would consider purchase of practice. Address No. 867 in care of the Journal. AMJ

POSITION WANTED AS LOCUM TENENS. Will finish interneship July first. Available July, August and first two weeks in September. First two years at University of Wisconsin, graduate University of Kansas, and licensed in Wisconsin. Address No. 868 in care of the Journal. AMJ

FOR SALE—Established practice of the late Dr. Dreyer at Wheeler, near Menomonie, Chippewa Falls and Eau Claire, and seventy miles from Twin Cities. Also large modern home with steam heat and oil burner. Will rent or sell, both very reasonable. Address Mrs. Celia Dreyer, Wheeler, Wisconsin. M

FOR RENT—Medical group to sublet modern office space on Wisconsin Avenue in Milwaukee, completely equipped, access to clinical and x-ray laboratory. Address No. 865 in care of the Journal. MAM

WANTED—Soon, an unopposed or nearly so, location for general practice of medicine. No real estate. Address number 871 in care of the Journal. MJ

WANTED—Eye, ear, nose and throat practice, in or near Milwaukee. Address Number 864, in care of the Journal. MA.

WANTED—Eye, ear, nose, throat specialist wants association with physician and surgeon. Willing to assist in general practice. Address No. 873 in care of the Journal. MJ

POSITION WANTED—As superintendent of small hospital. R. N., Anes., 15 years' experience in Wisconsin and Illinois. Fully equipped. Address number 872 in care of the Journal. MJ

WANTED—Locum tenens work by capable physician; available for short or long period; Wisconsin license; references; will not compete. Address number 851 in care of the Journal.

MATERNITY HOME for unfortunate girls. Secluded, private. Rates reasonable. For information write to Box 120, R. R. 5, Baraboo, Wisconsin.

WANTED—Mayo trained surgeon and obstetrician wishes to buy practice in Wisconsin. Prefers town of three to seven thousand. Address number 869 in care of the Journal. MJ

PHYSICIANS WANTED—A surgeon and a specialist in EENT for group work in southwestern Wisconsin. Completely equipped office. Established practice. Percentage basis. Address number 874 in care of the Journal. MJ

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RECENT WISCONSIN LICENTIATES

Name	School of Graduation	Last Address
Burch, Hobart Alexander	Harvard Medical School	120 So. Oneida St., Appleton, Wisconsin
Callaghan, Desmond Hays	Minnesota Medical School	Hayward, Wisconsin
Eisenberg, Walter Wilifel	Marquette Medical School	5755 No. Clark St., Chicago, Illinois
Heilman, George Curtis	Des Moines Still. Coll. of Ost.	Marion, Iowa
Inman, Richard F.	Illinois Medical School	4458 West Madison, Chicago, Illinois
Krueger, Emil Robert	Minnesota Medical School	Hayward, Wisconsin
Lutz, James Joseph	Rush Medical School	Phelps, Wisconsin
Newlove, Elwood Frank	Rush Medical School	1937 Arlington Pl., Madison, Wisconsin
Rian, Irville Spencer	Ohio Medical School	State Sanatorium, Statesan, Wisconsin
Saelhof, Clarence Charles	Illinois Medical School	4458 West Madison, Chicago, Illinois
Storchheim, Frederic	Rush Medical School	Box B, Wauwatosa, Wisconsin
Wyant, Marcus Earl	Indiana Medical School	St. Mary's Hospital, Madison, Wisconsin

The following licenses will be issued upon completion of credentials:

Helseth, Hovald Kjoss	Minnesota Medical School	Prescott, Wisconsin
Johnson, Herbert Paul	Minnesota Medical School	Middle River Sanatorium, Hawthorne, Wisconsin
Lancaster, Wilson McA.	Western Medical, Canada	General Delivery, Madison, Wisconsin

Basic Science Examination Questions of March 19th

HUMAN ANATOMY

1. Indicate clearly what each of the following are:
   1. Spinal nerve.
   2. Fiber tract.
   3. Nucleus of origin of a nerve.
   4. Nucleus of a cell.
   5. Lateral chain ganglion.
   6. Endocrine gland.
   7. Endothelium.
   8. Chromosome.
   9. Glomerulus.
   10. Red bone marrow.
2. Describe briefly the nasal cavity, giving its connections with other cavities in the living.
3. Trace the blood from the right atrium to the jejunum and return.
4. Give the course of the lymph flow from the ileum to the blood stream.
5. Describe briefly the elbow joint. Give its movements and the muscles causing each.

PATHOLOGY

Note: Answer *briefly five* questions.

1. Define: Reticulo-endothelial system; Atrophic cirrhosis; Leucocyte; Anemia; Leukopenia.
2. Discuss embolism.
3. Describe briefly the chief pathological lesions found in decompensated cardiac disease.
4. What is the series of events leading to the occurrence of tuberculous pneumonia (galloping consumption), and what are its results?
5. Describe briefly the kidney of chronic glomerulonephritis.
6. Describe briefly the most frequent types of carcinoma of the stomach.
7. Differential points between primary and secondary anemias.
8. Describe briefly the most frequent tumors of the uterus.

DIAGNOSIS

1. What are the evidences of fluid accumulation in the left thoracic cavity?
2. Describe briefly the physical signs of myocardial failure.
3. Give the diagnostic findings which lead to a diagnosis of obstruction in the portal circulation.
4. Give brief definitions of the following terms:
   a. Argyll Robertson pupil.
   b. Albuminuria.
   c. Alopecia.
   d. Anoxemia.
   e. Blepharitis.
   f. Exophthalmos.
   g. Eosinophilia.
   h. Ketosis.
   i. Hemorrhoid.
   j. Hemiplegia.
   k. Broadbent's sign.
   l. Scoliosis.

PHYSIOLOGY

1. What are the blood gases and how is each carried in the blood?
2. Define heart block and describe the important variations.
3. Outline the digestion, absorption and metabolism of carbohydrate.
4. Discuss the causes of muscular fatigue.
5. What are the various mechanisms by which the body may raise blood pressure in an emergency.
6. What forms of movement are seen in the stomach and intestines?
7. Define the following terms:
   a. Anoxemia.
   b. Vitamines.
   c. Dyspnoea.
   d. Tonus.
   e. Acidosis.
   f. Hormones.
8. Sketch a lateral view of the cerebrum and mark off the known functional areas.

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Therapeutic Notes

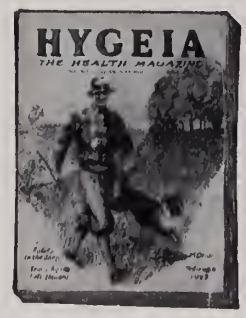
New and Nonofficial Remedies

In addition to the articles previously enumerated the following have been accepted by the Council on Pharmacy and Chemistry of the American Medical Association:

Ciba Co., Inc.:
Tablets Dial-Ciba, 0.03 Gm. (½ grain)
Clinadol Co., Inc.:
Clinadol Co.'s Cod Liver Oil Concentrate.
Lederle Laboratories, Inc.:
Surgical Maggots-Lederle.
Wm. S. Merrell Co.:
Fibrogen Local-Merrell:
Fibrogen Local-Merrell, 7 cc. vials.
G. D. Searle & Co.:
Gold Sodium Thiosulphate-Searle:
Ampules Gold Sodium Thiosulphate-Searle, 1 cc.
Ampules Gold Sodium Thiosulphate-Searle, 2 cc.
Ampules Gold Sodium Thiosulphate-Searle, 5 cc.
E. R. Squibb & Sons:
Thromboplastin Local-Squibb:
Thromboplastin Local-Squibb, 20 cc. vial.

The following article has been exempted and included with the List of Exempted Medicinal Articles (New and Non-official Remedies, 1931, p. 477):

Lederle Laboratories, Inc.:
Fluid Extract of Ergot. (Lederle)
Connaught Laboratories:
Insulin–Toronto, 40 Units, 10 cc.
Insulin–Toronto, 80 Units, 10 cc.
Insulin–Toronto, 100 Units, 10 cc.
Cutter Laboratory:
Diphtheria Toxin Antitoxin Mixture 0.1 L—(Goat)–Cutter.
Lederle Laboratories, Inc.:
Solution Liver Extract Parenteral (Lederle) Refined and Concentrated.
Eli Lilly & Company:
Merthiolate Ophthalmic Ointment 1:5000.
Tincture Merthiolate 1:1000.
H. K. Mulford Company:
Pneumococcus Antibody Globulin Type I–Mulford.
National Drug Company:
Diphtheria Toxoid, one vial package.
Pollen Antigens–National, one 5 cc. vial package.
Pollen Antigens–National, four 1 cc. syringe packages.
Pollen Antigens–National, sixteen 1 cc. syringe packages.
Schick Test (Peptone Diluent).
Von Pirquet Test for Tuberculosis.



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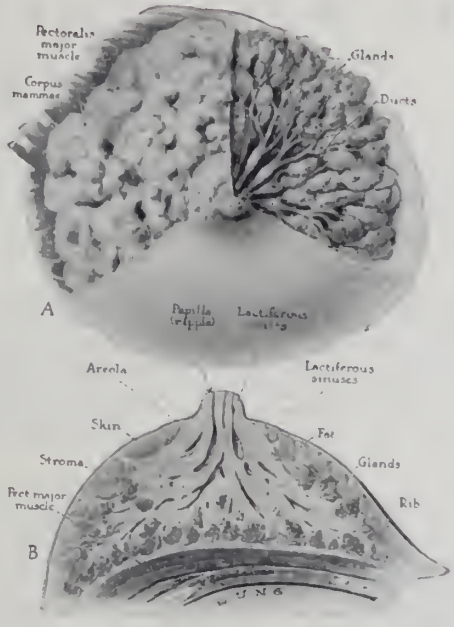

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Medical Course At least two years of college work, including English, foreign language, physics, chemistry and biology, are required for admission. The course requires at least four years for completion. During the first two of these years the work lies chiefly in the basal medical sciences outlined above. The third year of the course is devoted to didactic and practical instruction in the wards and out-patient department of the Wisconsin General Hospital. The fourth year of the course is devoted to practical instruction under the supervision of preceptors in the Wisconsin General Hospital and in affiliated institutions.

Courses in Nursing Courses in nursing are offered in the School of Nursing affiliated with the medical school. A residential course of 32 months is offered in the Wisconsin General Hospital to those who have completed a semester of specified work in the College of Letters and Science. This course leads to a certificate of graduate nurse. A residential course of 27 months is offered to those who have completed three years of college work in specified subjects either in the College of Letters and Science or in the Department of Home Economics. These courses lead to a certificate of graduate nurse and to a B. S. degree.

Graduate Courses Opportunity is offered for graduate work in the preclinical and the clinical medical sciences and in hygiene and public health. For further information address C. R. Bardeen, Dean, Medical School, Madison, Wis.

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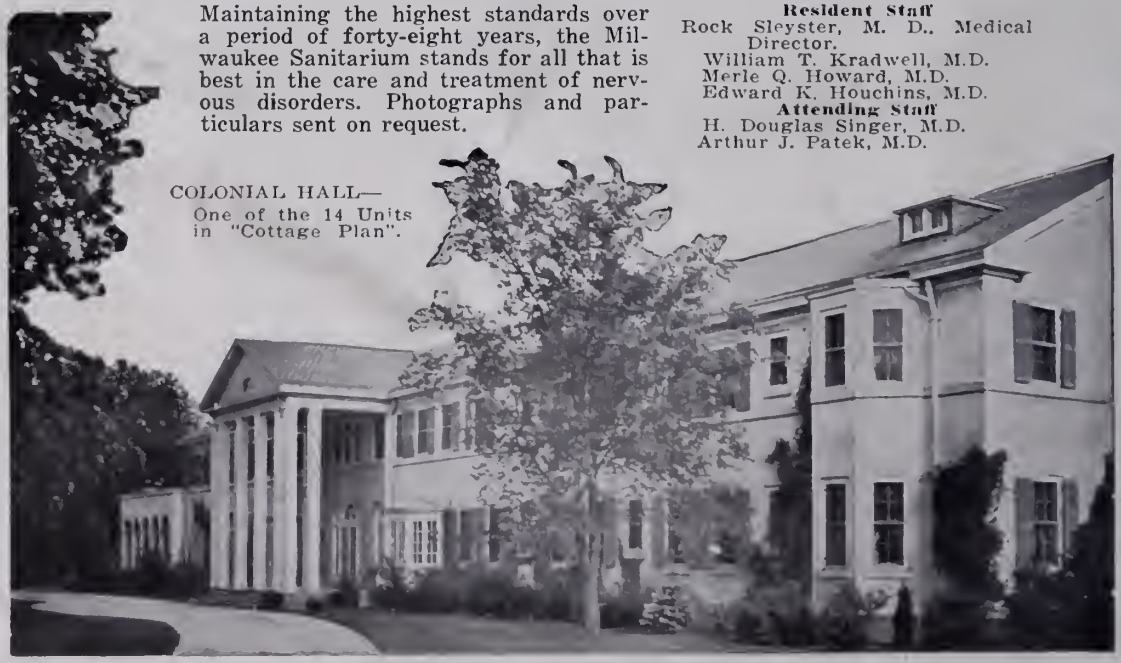

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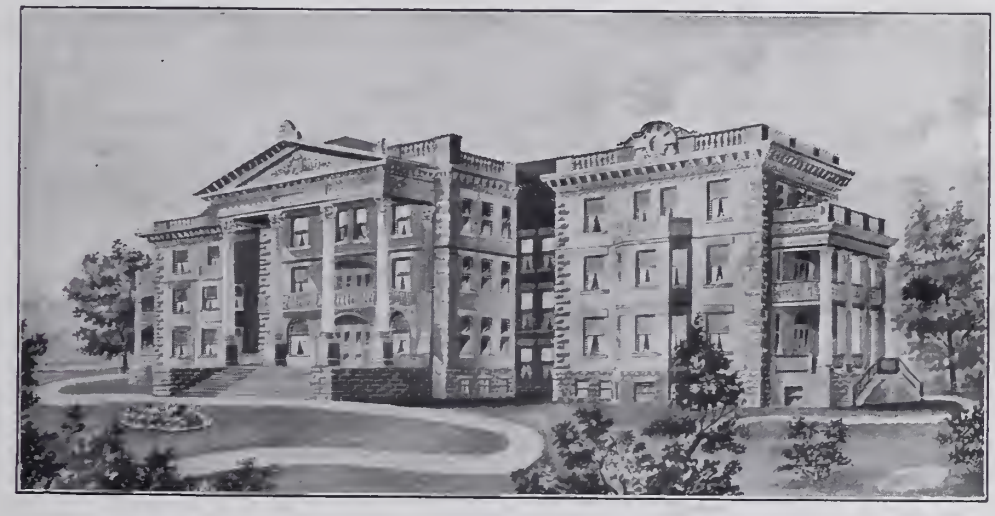

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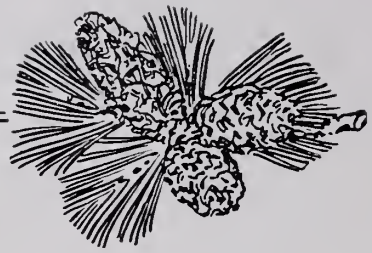

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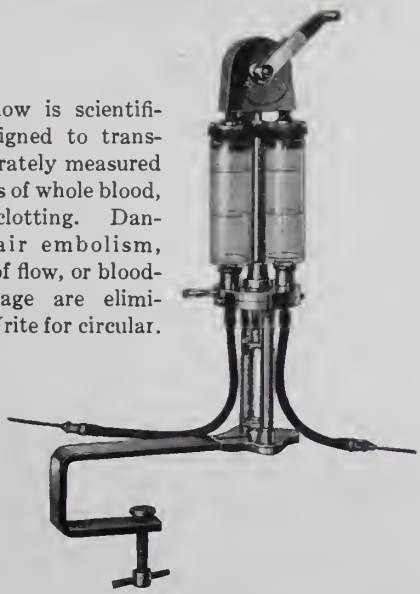

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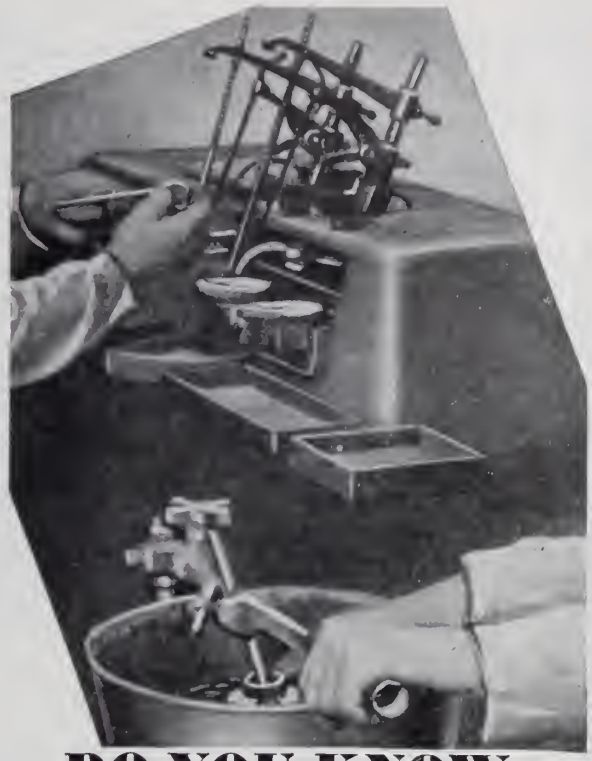

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The Wisconsin Medical Journal

Volume XXXI JUNE, 1932 No. 6

Organization of Cancer Clinics in General Hospitals*

Chairman W. D. Stovall: The attention of all hospitals, surgeons and general practitioners of medicine, has been focused on the problem of the early diagnosis and treatment of cancer by the activity of the American Society for the Control of Cancer and the American College of Surgeons. The former has engaged in an extensive lay education campaign as well as a campaign for the development of better medical facilities for the proper diagnosis and treatment of cancer, and the latter has been particularly interested in the organization of cancer clinics in general hospitals throughout the country. In order to gain a clearer understanding of the operation of these clinics and to get suggestions as to how modern methods for the diagnosis and treatment of cancer can be more effectively applied in small cities and rural districts, I have invited for this occasion men who I am sure will contribute to our understanding of the subject.

I shall first call upon Dr. Crowell, Associate Director of the College of Surgeons and Director of Clinical Research for the College.

Dr. Bowman C. Crowell (American College of Surgeons, Chicago):

The invitation extended to me indicated that I am to talk about what the American College of Surgeons is doing about cancer clinics. I would prefer to start by telling why the American College of Surgeons is interested in cancer clinics. We have been interested in the subject of cancer since the organization was started and have had committees working on different phases of the subject. To date, the outstanding work of the college in connection with cancer, with which Dr. Bloodgood has been so much concerned, is that of the Committee on Bone Sarcoma. We have reports on over fifty cases registered with us that are living five years or more following treatment without symptoms of the disease.

That emphasizes one point; cancer, in this form, is a disease which can be cured. That gives the summary: Not all forms of cancer, not all stages, but cancer in some forms, if taken at the right time and given the right sort of treatment, can be cured. Then why not spread this information?

Through our Committee on the Treatment of Malignant Diseases, of which Dr. Robert B. Greenough of Boston is chairman, we have been collecting information concerning different types of cancer through a number of selected clinics devoted especially to work on cancer. This information has emphasized the hopeful side of cancer and has pointed out the need of more places in this country where patients can get early diagnosis and efficient treatment.

The next step is to try to increase the number of places where patients can get early diagnosis and efficient treatment, and thereby make an impression upon the terrific mortality which will amount to approximately 150,000 deaths in this country this year.

We realize that the best results have been obtained, for the most part, with few outstanding exceptions, where there has been the required collaboration between the physician, the pathologist, the radiologist, and the surgeon. I include representatives of the various surgical specialties.

Dr. Ewing, Dr. Greenough, and a number of others, have made popular the statement that cancer is no longer a one-man job. That is really the basis for the work which we have undertaken; i. e., to get each physician who has a case that is potentially cancer or that is cancer, to work with his confreres in establishing an early diagnosis, and advising as to the best form of treatment.

We know there are centers where that already has been brought about, but, taking it by and large throughout the country, the

* Round Table Discussion at the 90th Anniversary Meeting, State Medical Society of Wisconsin, Madison, 1931.

cancer patient has not been getting the best available medical knowledge.

How are we going to bring this about? We can not have cancer institutes all over the country. They cost too much. We can not have hospitals everywhere devoted solely to cancer. It is a question whether that would be desirable, but we have general hospitals everywhere throughout the country at the present time, and a great many of these general hospitals are equipped physically and with the personnel to bring to the patients the best available medical knowledge if they will go about it in the right way.

With the general hospitals scattered throughout the country as they are, with their equipment and personnel, it seems that through them is the means most readily available for obtaining the greatest efficiency in the early diagnosis and treatment of cancer.

So we have drawn up a standard for cancer clinics in these hospitals. We have, as a basic factor, the necessity of cooperation (surgeon, pathologist, radiologist) in order to secure early diagnosis and efficient treatment.

We realize the necessity for the education of the public to take advantage of the facilities made available in these hospitals. No organization has done more along that line than the American Society for the Control of Cancer, represented by Dr. Rector.

It is extremely pleasing to me to see such a meeting as we are having here this noon, sponsored by the State Medical Society. The state health officers and the city health officers can do an inestimable amount of good in making possible these clinics, informing the public concerning them and getting the patients to them.

Cancer is becoming more and more a specialty. There is one point in connection with that, which, as a representative of the College, I want to emphasize. That is the role of the family physician. The College, as an organization, stands behind the practitioner of medicine. We do not wish to have our advocacy of the cancer clinics interpreted as by any means taking away from the general practitioner his patients or of disturbing the relation between the general practitioner and his patients. We want to see these clinics, the details of which I shall speak in a few moments, so organized that they will be placed at the disposal of the practitioner, with privileges and facilities which he can not have at his disposal in any other way, so that he may bring his patients to these clinics and get the benefit of the advice of those who see more cases than he does and who treat more cases than he does, without disturbing the relationship between the patient and the practitioner. That point we wish to emphasize.

If the practicing physician or surgeon suspects that his patient has a luetic infection, he sends him to the laboratory for a Wassermann test. This in no way interferes with the relation between the practitioner and his patient. A cancer clinic should be organized along this same line. Those are the general principles which have led us to sponsor cancer clinics, and the principles which will guide us in the advice which we give concerning the formation of such clinics.

The standard itself, which was originally based upon and has been evolved from our own studies in the course of years, and upon the studies of the American Society for the Control of Cancer, is simple and fundamental. I think none of the clauses will be changed within the next few years unless there are some monumental discoveries.

STANDARDS

In 1927, the American Society appointed a committee, Dr. Greenough, Dr. Ewing, and Dr. Gerster to make a survey of the country, which they did, in order to see what facilities were available for the treatment of cancer and to make recommendations. They made certain recommendations and we have used these, with certain additions, in the development of our standard. That standard I am going to read clause by clause and will comment on each clause.

"1. Organization. There shall be a definite organization of the service, and it shall include an executive officer and representatives of all the departments of the hospital which are concerned in the diagnosis and treatment of cancer. The services of a secretary and of a social service worker shall be available."

A simple reshuffling of the staff of the hos-

pital will not accomplish an organization adequate for the work of a cancer clinic. You must have an executive officer, who is the executive officer of the clinic, and behind him representatives of each of the departments of the hospital, pathology, radiology, surgery, internal medicine, and the surgical specialties. To them must be added a secretary and social service worker, in order to keep accurate records, and in order to secure complete follow-up on the cases.

The members of the staff should be selected because of their interest in the subject of cancer, because of their willingness to devote a certain amount of their time to the organization, and because of their knowledge of cancer. The radiologist must know something about the relation of his science to cancer. It is not any old radiologist who can fill the position. It is obvious that he must have special training.

With regard to the pathologist, I have been a pathologist for twenty-five or thirty years, and every pathologist can not fill the position in a cancer clinic. He should have had special training or be prepared to get special training in the diagnosis of cancer in the early stages, in recognition of the different types of cancer, and to know something about its radiosensitivity. Cancer pathologists are coming to be quite a class. Unfortunately, we have not as many of them as are necessary for the completion of our program.

"2. Conferences. As an essential feature of the service there shall be regular conferences or consultations, at which the diagnosis and treatment of individual cases are discussed by all members of the clinic who are concerned with the case." When a patient comes to the clinic, after a preliminary examination, he shall be seen and discussed by the pathologist, surgeon and radiologist, and frequently the internist. The diagnosis arrived at is the result of group study. He will have the resulting group opinion as to diagnosis and treatment. Cancer clinics are going to be one of the greatest means of educating doctors.

"3. Patients. Reference to the cancer clinic of all patients in whom the diagnosis or treatment of cancer is to be considered shall be either voluntary or obligatory, in accordance with the vote of the medical staff or of the governing board of the hospital."

In most of the cases it will be better to start in making reference to the cancer clinic voluntary. Then if the clinic staff cannot do its work well enough to make the members of the general hospital staff realize that the patients are getting better results in the clinic than they can give themselves, the clinic should not survive. As the members of the clinic staff show their efficiency in the early diagnosis and treatment of cancer, other staff members will refer their cases to them, or the patients will demand that they be referred.

"4. Equipment. In addition to the diagnostic and therapeutic surgical equipment which is required in every approved general hospital, there shall be available an apparatus for x-ray therapy of an effectiveness which is generally agreed upon as adequate, and an amount of radium sufficient to insure effective treatment." That is put in very general terms in this minimum standard, as we did not want to be too dogmatic on the subject.

"5. Records. In addition to the records which are required in every approved general hospital, there shall be additional records of: (a) The details of the history and of the examination for cancer in different regions of the body, such as are indicated on the form records which are recommended by the Committee on the Treatment of Malignant Diseases, American College of Surgeons. (b) The details of the treatment by radium or x-ray as indicated on the form records which are recommended by the Committee on the Treatment of Malignant Diseases, American College of Surgeons. (c) Periodic examinations at intervals for a period of at least five years following treatment."

"6. Treatment. The treatment of cancer patients shall be entrusted to the members of the staff of the cancer clinic, except in cases in which adequate treatment in accordance with collective recommendation of the staff of the cancer clinic can be procured otherwise."

I expect that these cancer clinics are going to be widespread, and I am anxious to see them evolve in the general hospitals through-

out this country as rapidly as the hospitals can realize the necessity for proper organization for this service, for training personnel of their clinics for this particular purpose, and providing the equipment.

Mr. Chairman, I would like to see the state of Wisconsin take a leading part in the development of these clinics, which it has not done up to the present time.

Chairman Stovall: Thank you very much, Dr. Crowell. It was very interesting to hear your explanation of the suggestions of the College of Surgeons.

I would like to have our remarks made as pointed as possible, forgetting that we are surgeons or physicians or pathologists. We are looking at the problem of cancer, the treatment of it, the prevention of it.

How are we going to make effective in a general hospital a cancer clinic? Is the surgeon going to consider the cases his cases? Is he going to say, in the last analysis, what the treatment shall be? Is he going to refer all of his cases to the executive officer of the Cancer Clinic?

We have a number of general hospitals. There are not enough pathologists in the country to fill all of the laboratories. Is a staff going to be able to name somebody as the clinical pathologist who previously was practicing medicine or surgery or gynecology and took upon himself the arduous duties of the laboratory, and once or twice a week went in and looked at the sections? These are vital questions, the working out of which means success or failure of this phase of the fight against cancer.

We are fortunate to have with us Dr. Rector, who represents the American Society for the Control of Cancer and who is now making a survey of the State, at the request of the State Medical Society, to determine the present status of the care of cancer cases and from the information his survey reveals to make recommendations for improvement.

Dr. F. L. Rector (American Society for the Control of Cancer, Evanston):

I am not going to pretend to answer Dr. Stovall's questions because I think the answer to them has to wait until we have worked with these clinics by the trial and error method. A great many of these problems cannot be worked out beforehand. They are something entirely new. We might sit around this table and work out a satisfactory program, but the first hospital that undertook to apply that program without a knowledge of the personnel or the personalities of the hospital executive or clinical staff might find it impossible to make it function.

I, therefore, think we should make a slow start on this work and should keep in mind two or three things in its development. One is, to know something, as far as we are able, of the extent of the problem, i. e., the amount of cancer to be cared for by the clinic. The American Society for the Control of Cancer estimates that for each cancer death in a community there are three living cases. In Wisconsin this ratio would indicate that there are from ten to eleven thousand living cancer cases at this time. This is a considerable number, but it is scattered over a large territory. There are about sixty hospitals in this state of more than 50-bed capacity each. This gives comparatively few cancer patients for each hospital. But let us make another comparison, that is, the number of cancer patients for each licensed physician in Wisconsin. There are about three thousand licensed physicians, thus giving three cancer patients per physician. I think this factor alone is the biggest argument for the organization of cancer clinics. In these clinics the cases will be considered by small groups of men who are primarily interested in and trained for cancer diagnosis and therapy. Cancer will never develop into a disease of epidemic form as do measles, influenza, etc., but the fact that practically all cancer patients die of the disease is what makes its study and control of such prime importance.

I think that in the development of the cancer clinic two things should be kept in mind. One is the opportunity for better service to the cancer patient. The other is that in the present state or lack of cancer knowledge throughout the country these cancer clinics and cancer centers should be used as educational centers for the benefit of the profession and allied groups, such as hospitals, nurses, social workers, etc.

Dr. Crowell has said he believes there is going to be a very widespread organization of cancer clinics throughout the country. I think that is true, but I also feel that probably a certain number will not continue to function for any considerable period of time. Rather there will develop a few well organ-

ized, well equipped and well staffed clinics in each state. These groups will be placed in strategic locations as regards population to be served, transportation facilities and similar problems. They will become part of the medical teaching facilities of the state and in this way serve a very useful purpose.

I think the plan of preceptor teaching of fourth year medical students as carried out in Wisconsin is a splendid way of getting some of this practical work into the minds of the undergraduates in medicine. With the better appreciation of the cancer problem reflected in the organization of special cancer centers and the full use of these centers for undergraduate and postgraduate teaching, I believe there will be a marked improvement in the cancer situation.

I do not believe we should wait on the development of facilities and personnel up to a given minimum standard of training and experience before undertaking organized cancer work. To do so would mean the loss of from five to ten years' time. It would be better to organize with the facilities and experience now available for that is what cancer patients have been getting in the past. The workers in these special clinics could develop into better diagnosticians and therapeutists through experience, and in the meantime training facilities could be developed for others.

There is one more point I wish to make which may seem trite, but which I think is well worth bearing in mind. It is this: Cancer is probably the only disease in which the medical profession, by its ability and skill, alone can effect a cure. If skillful surgery or irradiation therapy produces a cure the physician is entitled to all the credit, for left alone, the disease would undoubtedly progress to a fatal termination. In no other disease can the profession claim such brilliant results, so I believe the medical profession has a task and a challenge in this question of cancer control. It is a challenge because of its unknown etiology and its rapidly mounting mortality.

I feel, and I think others feel also, that it is better to defer any widespread public educational propaganda program until after the medical profession and the hospitals of the country are better oriented to the proper diagnosis and treatment of this disease. For that reason, we are very glad to cooperate with the State Medical Society of Wisconsin and other state societies in making a survey, such as is now under way in this state, to determine the facilities for the treatment of cancer, where cancer is being treated, how it is being treated and who is doing the work.

When the answers to some of these questions are found and a program developed for the State Medical Society, the State Department of Health, and other organizations interested in this work, I think we will be in a position to go to the people of Wisconsin and tell them what cancer is, what can be done about it and where they can get proper treatment.

Chairman Stovall: We have another guest who is shortly going to open a cancer clinic in Michael Reese Hospital. I am going to ask Dr. Cutler to give us some of the things he thinks are essential qualifications for conducting cancer clinics.

Dr. Max Cutler (Director Tumor Clinic, Michael Reese Hospital, Consultant on Tumors, Hines Veterans Hospital):

No one more greatly appreciates the splendid work of the Special Committee of the American College of Surgeons and the American Society for the Control of Cancer in the organization of tumor clinics than those who have actually attempted to organize one of these departments.

The first problem with which one is confronted is the selection of the staff. This is a problem which must necessarily vary in different institutions.

There are several fundamental and basic principles which must be established in the successful organization of any tumor group. To my mind one of the most important is the matter of consultation before any therapy is executed. The great importance of this is obvious. You will all agree that the fate of the cancer patient is greatly influenced, if not largely determined, by the first therapeutic procedure. In the organization of the Tumor Clinic in the Michael Reese Hospital, Chi-

cago, this principle is inviolable. Once the diagnosis of neoplastic disease is established, the patient is immediately given the benefit of consultation. The therapeutic procedure is executed by the member of the group most experienced in the particular condition under treatment.

The next most important feature is that the tumor clinic be thoroughly equipped with x-rays and radium, and more important, a trained personnel.

The third important feature is a follow-up system, as it is only by this method that the comparative results of various therapeutic methods can be estimated.

The recommendation of the Special Committee of the American College of Surgeons as regards the minimum quantity of radium necessary is, in my opinion, sound. This recommendation is that tumor clinics be equipped with at least 200 milligrams of radium. If the French radium technic is adopted, small amounts of radium employed over long periods of time are highly efficient in the treatment of certain types of cancer. Under these circumstances, external radiation must be executed by means of a high voltage x-ray machine.

The use of large radium packs, for economic reasons, must necessarily remain in the hands of large cancer hospitals, or in tumor clinics of large general hospitals. There are numerous advantages to this method.

There appears to be considerable difference of opinion as regards the wisdom of establishing tumor clinics in general hospitals. Some authorities (for example, Professor Reguad of the Curie Institute, Paris) believe that the most efficient method of organization is that by which the treatment of cancer is segregated and concentrated in a limited number of large cancer institutes. Personally, I agree with Dr. Ewing that both types of organization are necessary. Extensive cancer research and the development of improved therapeutic methods must emanate from the large centers where experience is based upon adequate clinical and pathological material. Such centers should also perform the important function of training and education. The smaller units in general hospitals can best function by restricting their therapeutic procedures to such conditions as are commensurate with their equipment and the experience of their personnel. The larger clinics and cancer hospitals may then act in a consultant capacity and execute such special procedures as may be indicated.

Dr. Joseph Colt Bloodgood (Baltimore):

The most significant fact which stands out when you study the attempt to control cancer in the past forty years is the failure to recognize that cancer is largely a hopeless disease, because neither the people nor the medical profession have realized that in its incipiency it may be preventable and in its early stages curable. Even today the largest effort of the medical profession and the largest amount of money is expended in building and equipping hospitals for more and better surgery; equipping private clinics and hospitals with more powerful x-ray machines and larger amounts of radium.

We are also making every effort to increase the number of surgeons specially trained in the operative treatment of cancer; in radiotherapeutics, with both x-rays and radium, and now—even more important—technicians trained to make fresh frozen sections and stain them properly in the operating room, so that the pathologist may help the surgeon with his expert microscopic eye and differentiate cancer from the lesion that is not cancer, and to give further advice on the degree of malignancy of the cancer cell seen with the high-power lens.

There is no question but that in standardizing general hospitals throughout the country, every effort should be made to improve the personnel of the operative surgeon, the radiotherapeutist, and the diagnostic group including the technicians, and, for cancer, especially the pathologist. But this is not sufficient, without providing for a better organized, continuous and cooperative educational effort to inform the public on the importance of selecting the family physician while well

and seeking the advice of this family physician as to a periodic examination, and further advice on what symptoms should lead them to come at once to the doctor in the interval between the annual examinations.

We must bear in mind that cancer is but one of the diseases for which the general hospital is planned. The very important question must be decided as to whether the general hospital should be broken up into fracture, thyroid, tubercular, cancer, heart and other types of clinics devoted to special diseases, instead of emphasizing the necessity of people seeking the advice of their physicians before they know what disease has given them trouble.

Returning to cancer again, the improvement in our results will be shown best in the mortality statistics as reported from time to time by the federal government. Should we not have this constantly in mind when we discuss and plan cancer clinics in general hospitals?

During the forty years of our attempt to cure cancer, the entire character of the patient's local and general condition has changed in the past ten years as compared with the previous thirty. In the first ten years more than fifty per cent of patients admitted to hospitals were in the hopeless stage of cancer, and the chances of a permanent cure were less than ten per cent. In the past ten years the hopeless cancer patients have been reduced to less than ten per cent, and the probability of relief has been increased to more than sixty per cent.

This distinct improvement in the results can best be explained by the enlightenment of the people, not by the improvement in the equipment of general hospitals, nor in diagnosis, surgery or radiotherapeutics.

Should our hospitals and personnel remain the same, but the number of people who consulted their family physician while well increase, the cures of cancer through prevention in the stages which are not cancer, and the cures of the early stages of cancer by surgery and irradiation would be so tremendous that it would be quickly seen in the mortality statistics of the government.

Therefore, in all our attempts to control cancer through prevention, surgery and irradiation, we must not overlook that up to the present time sufficient attention has not been given to the education of the people by every possible means.

It is also very important for the public, for the medical and dental professions and especially for the younger generation of surgeons to constantly bear in mind that the conception and execution of the most efficacious operations for cancer, were made eminently successful between 1890 and 1900. This art runs the risk of being lost.

TWO NEW GROUPS

Two new groups come into the picture of cancer control which were absent in the first ten years—the microscopic pathologist, to interpret frozen sections in the operating room, and the radiologist, who helps in the diagnosis with the x-ray picture and takes charge of the radiotherapeutics with x-rays and radium. These two must be equally trained.

The more people enter a general hospital quickly after the first sign or symptom of a local lesion that may suggest cancer, the more they will need the entire diagnostic group of the general hospital to complete the diagnostic survey and the more they will require the therapeutic services of the different specialists.

It is therefore impossible for the cancer clinic to get on without the aid of the entire medical staff of the hospital, and each specialty needs the help of the microscopic pathologist and the radiotherapeutist, and the x-ray diagnostician.

If there is any proof that the establishment of cancer clinics in general hospitals will increase the number of cures of cancer and decrease the mistakes in diagnosis and therapy, they should be established at once.

It must also be borne in mind that, although a city may need more than one general hospital, one institute with sufficient radium and one supervoltage x-ray tube, and one radiotherapeutist would be sufficient to take care of radiotherapeutics of all cancer cases. Four hospitals of moderate size would be better off with one expert microscopic pathologist than with four less well trained individuals.

However, there would be one very useful result on the organization of cancer clinics in the general hospital—it will aid in a movement of educating the people, of the general medical and dental profession, and it would stimulate the provision in various localities of microscopic pathologists, radiotherapeutists with a sufficient amount of radium, and sufficiently adequate x-ray tubes.

Whether there is an organized cancer clinic in a general hospital or not, the hospital must be prepared to receive cancer patients, provide for proper diagnosis and treatment, or refer them to other hospitals better equipped.

In this very brief discussion of this very important problem of cancer clinics I wish, in conclusion, to emphasize another vital department in any cancer clinic, no matter whether it is in a general or special hospital —the records, the follow-up system, the preservation of original tissues and permanent sections. The most important parts of the record of a patient today are correct names and addresses of patient, family, friends and physicians. These patients should be written to every three months after their discharge for the next three years; then twice a year for the next two years; after five years annually. So far it seems impossible to persuade more than five per cent to report before they are written to. But when the patients and their physicians are requested to report at the above intervals, the per cent of those lost track of is insignificant.

The preserved sections must be studied and restudied. The preserved tissues become more valuable as the record becomes older. They allow restudy with new stains, or, when sections are lost or faded. Museum specimens which cost much in time and space, and the preservation of large amounts of tissue is becoming less and less necessary as cancer becomes more and more a microscopic disease. If in the past the money spent on museum specimens and the care and preservation of tissue in large jars, had been spent on a follow-up system, our control of cancer would be greater today. There is no question that, to increase the prevention of cancer and the cure of the earlier stages of cancer, there must be a greater educational effort among the people, the essential part of which, to repeat, is to persuade them to select a family physician while they are well.

There is not much use informing the general practitioner about the precancerous lesions of the skin and mucous membrane of the mouth and the cervix of the uterus, or the earliest signs and symptoms of internal cancer, unless their patients consult them in this early stage.

In the discussion of the organization of cancer clinics, we must bear in mind that in this preventable stage of cancer and in the incipient stage of cancer, we need diagnostitians of the highest training, clinicians, microscopic pathologists, roentgenologists, and ultimately a complete diagnostic staff with the technicians. The operating surgeon today must not be satisfied until he can get the same results as the pioneer operators up to 1900. Physicians who are to employ radium and deep x-rays in therapy require the same training and experience as the surgeons. There must be sufficient radium and the high-voltage tube must be employed for therapy.

With transportation as it is in this country, no case of cancer should be deprived of this opportunity for a cure.

Dr. W. D. Stovall: Mr. Chairman, I have no question to ask, but I wish to express my appreciation. It is delightful to have Dr. Bloodgood point out the simple way to prevent such a devastating thing as cancer.

I am tremendously impressed with the fact that we have gotten past the period where we learn only by clinical pictures. In medical schools, we are still teaching by clinical pictures, and every student of medicine goes out with an idea that a certain disease has to appear in a certain way, that it always appears in that way, and if all the characteristics are not present, it is not that disease. It may be likened to a little boy who, when getting ready for bed at night, kneels down and says, "Now I lay me down to sleep," and his heart and mind are on the baseball game.

We forget we know a lot more chemistry than we did twenty-five years ago. We know a lot more about bacteriology than we did twenty-five or thirty years ago. We know a lot more about psychology. Every case is a problem, and the opinion of one man

alone is not sufficient. It makes no difference how common it is.

I wish to thank Dr. Bloodgood for this splendid presentation.

DISCUSSION

Dr. R. D. McClure (Detroit, Mich.): Nine months ago, we started a cancer clinic at the Henry Ford Hospital. I think the question you brought up, whether the chief surgeon or executive officer of the clinic would control the clinic and perhaps direct all the cases, is one that was in some of the men's minds when we first organized our clinic. I, as executive officer, feel like the least important man in the clinic. The doctor presenting the case makes the final disposal of that case but he has had the opinion of the pathologist, the radiotherapist and the special surgeon.

The cases are registered only when the pathologist shows microscopic sections at the clinic. The roentgenologist presents an opinion as to what he thinks about the treatment, whether it is a radiosensitive tumor or not. The special surgeon gives his opinion as to whether he thinks the operation offers possible cure or palliation. So there is a consensus of opinion before anything is done. The differences which formerly existed between these groups are being eliminated. The clinic has been most stimulating and has led to an agreement that did not seem possible. We registered about 275 cases in nine months' time.

Dr. Bloodgood: You have not added a new personnel—the same pathologist, the same surgeon, but you have come together?

Dr. McClure: We have exactly the same personnel but this coming together formally and discussing in a group all cases is leading to better understanding and cooperation. This is also stimulating us to more careful follow-up work, as these charts are always present at the meeting.

Dr. R. G. Mills (Fond du Lac): There is no question in my mind regarding the necessity for better treatment of cancer patients. I can see that it would be very easy for a hospital like Michael Reese, or one like the Henry Ford Hospital, where the endowment of the institution itself cares for the cancer clinic, with relatively little expenditure, to organize a cancer clinic.

Dr. Rector mentioned a moment ago that somewhere between ten and eleven thousand living cancer patients are in Wisconsin. I fancy that at least three-fourths of those patients will be cared for by the individual physician or by very small groups in towns, where the hospital is a privately owned, privately operated institution, which has no funds whatever for the establishment of a cancer clinic. Even if that institution had such funds or had such plans for a cancer clinic, I doubt very much whether it would be possible to get gathered together from the staff of that hospital those that would be necessary for the operation of just such a clinic on an approved plan.

That is the situation which faces practically the entire profession of the state of Wisconsin, outside of a few places. I have been listening thus far, very carefully, for any hint which would give a clue for something constructive in those cities of population of 50,000 to 60,000 or thereabouts, where such a plan as this could be put into effect, but, unfortunately, I have not yet gotten such a clue.

I can see that each clinic, composed of anywhere from two to six or eight or ten men can do something for the better care of patients who come to them. They can perhaps carry on the diagnosis and treatment from their own personnel. If they happen to have a pathologist in their group, well and good. If they have a surgeon who is able to operate successfully and skillfully, so far so good. But when it comes to providing that clinic or that hospital with an adequate amount of radium, with x-ray apparatus that will give something like 200,000 volts, and a radiologist who is sufficiently trained to give superficial as well as deep x-ray therapy, that is quite another matter and that, I think, is really the problem which faces the physicians of the state of Wisconsin.

If anybody has any constructive suggestion as to how a small group, in a relatively small town, can better handle cancer patients, I would like to hear it. I would also like to know whether it would be possible, in the ultimate survey of the state, to find out where deep x-ray therapy can be satisfactorily given, and where such patients as have been cared for to the best of our ability, can be referred for that which we are unable to give.

If these points are taken into consideration in the survey of the state of Wisconsin, then I feel we are really getting somewhere, so far as meeting the needs of this state is concerned, but unless that is done, I do not believe we will be able to touch at least three-fourths of the cancer patients of this state.

Dr. E. F. Schneiders (Madison): I trust you will pardon the presumption of my speaking immediately following Dr. Mills, because I shall not try to answer his questions or challenge to the group; perhaps I shall, however, add a few more questions of my own.

As some of you know, my interests, since I started to practice, have been primarily gynecology and obstetrics. I have kept the record of our cases of endocervicitis. In our group, which numbers four men, we have treated and cured several thousand cases of endocervicitis. We have yet to see a case of carcinoma of the cervix develop in a case adequately treated.

This follows the report of Graves, who reported some 5,000 cases of adequately treated cervices in women, only nine of whom developed carcinoma of the cervix following this adequate treatment.

I feel, as Dr. Mills does, that the organization of the large cancer clinic, while it is a wonderful devel-

opment, aid and advance, will care for but a very small fraction of the cases.

This is exemplified by the Memorial Hospital of New York, than which there is perhaps no greater in this country and very few in the world. Right in the shadow of that institution, the vast majority of cancer cases in greater New York are treated by the individual physician, many by inadequate physiotherapy, many by inadequate methods of other types.

In seeing cases that come in for consultation and cases that come for the first examination in pregnancy, Pollack has stated that approximately eighty-five per cent of all women have endocervicitis. In almost 2,500 maternity cases cared for by myself, almost one hundred per cent of the women who have had children have had a certain degree of endocervicitis. Ninety per cent of all the nullipara who come to my office for their first examination have a certain degree of endocervicitis. A large per cent have been through the hands of the general men. Many have been operated on by the general surgeon who operated for various pelvic conditions but disregarded this lesion.

If, as Dr. Bloodgood emphasized, seventy per cent of all women with cancer of the breast can be cured if seen early enough, if it is possible for Ward and Farrar and Haley to cure approximately sixty per cent of all cases of carcinoma of the cervix that come early, it seems the time is here for a method to be evolved whereby the general profession can provide for their patients this protection against a cancer death. If cancer merits great expenditure of funds for research, if early treatment of cancer saves lives, then why not place proper emphasis on pre-cancerous lesions.

In speaking before the various county medical societies on the subject of the early recognition and adequate treatment thereof, it has been perfectly astounding to have men come and say, "I absolutely admit that I have not treated cases of endocervicitis. We have simply taken them for granted and let them alone and told the patient many times that after she was through with child bearing, she could come back and we would fix the lesion."

As I see it, the cancer problem is for us a local problem. As Dr. Stovall knows, we have conferred on this subject many times in great detail. I was hopeful that some plan might be evolved that would be helpful to us in this community and in similar communities.

In order to promote an early beginning for Dane County I would like to offer the following tentative plan to be altered as conditions would warrant:

1. The appointment of a cancer committee composed of members of the Dane County Society, that committee to be in charge of the development of the cancer program.

2. The development of one efficient cancer or rather the so-called tumor clinic to be located at the hospital best qualified to offer the recognized facilities and to be supported by the entire profession in the community. This clinic must also act in diagnostic and advisory capacity for other physicians and must refer the referred cases back to their physician or hospital.

3. The organization of a central bureau of tumor material in this clinic comprised of complete records and gross microscopic and autopsy material. These records would contain complete case histories, operative findings, gross and microscopic specimens, treatment and follow-up information, a carbon copy of which should be presented to the family physician of each patient coming into the tumor clinic.

4. Clinics and meetings with demonstrations and discussions for, with and by the physicians of this entire area.

5. The organization of a combined medical and lay public committee to supervise the education of the lay public and promote its support both moral and financial.

Some such plan based on the above cardinal points would answer our immediate need which is not so much the organizing and financing of a great cancer institute as it is the organizing of a tumor clinic which will educate the profession, and, through them, the public and thereby make available the knowledge which the profession already has regarding the recognition and treatment of pre-cancerous lesions as well as the recognition and treatment of early cancer. I feel a great immediate good can be accomplished if the profession and the public will not hesitate and wait for further great discoveries to be made in cancer but will instead immediately avail themselves of the existing knowledge.

Chairman Stovall: We would like to have Dr. Crowell make a few closing remarks.

Dr. Crowell: I thank you for the opportunity of appearing before you and starting the discussion. I think it has been very effective. A number of the questions brought up will be answered by the men doing the work.

I would like to say we do not consider this the last word or the only word in connection with the cancer problem, but, for attacking the work throughout the country at large, it is the best way we know for making it effective. Those institutions that can not have full deep x-ray therapy apparatus or at least 200 milligrams of radium can still do good work by having conferences and giving their patients the benefit of good diagnosis and advice as to treatment, and sending them where they can get that kind of treatment which they know to be the best. That does not leave it to what one man is able to do with the poor equipment and poor training that he may have. It puts it into the hands of a group of men and lets them advise the patient.

That, I think, is the principle which will live for all time in the recommendation we are making.

Chairman Stovall: I want to thank our guests and all those who have joined in the discussion of this subject for their assistance to a better understanding of the methods to be employed in our fight to control cancer.

Impromptu Remarks on Cancer*

By CHARLES H. MAYO, M. D.
Rochester, Minnesota

It has been a great pleasure to attend this meeting. We are all neighbors up here in the Northwest. You have splendid men in Wisconsin and we have a similar lot in Minnesota.

When the time comes around for a medical meeting to occur within a few hundred miles I get restless and want to attend. I used to take active opposition to all things that were read which did not agree with my own opinion. As time went on, I softened greatly, and I do not oppose things so actively. However, I think it is best not to have too much discussion.

Nevertheless, changes have come in medicine during the last years. Fifty years ago, I used to drive my father about and hold the horse while he was in the house a long while. It made me very restless, but, since then, with a family of my own, I realize he kept me out there in the buggy so he would know where I was, rather than just to hold the horse.

As I approached the practice of medicine I was worried. It seemed to me that just about everything had been discovered concerning medicine, and that a lot of the adventure had gone. I had kept thinking of the wonderful adventure that must come to all doctors through research, and medical and surgical procedure. I had read Hare; in a way he knew how to cure everything, but unfortunately I could not remember everything he wrote about medicine. I read old Barthlow with interest. He was a wonderful doctor. He must have held his patients very much attached to him, because they stuck to him and he never gave up until they got well or died. While there were better medical men in his day, he was not to be deterred; he always planted his feet firmly on the ground with the idea that some day something would be discovered for that particular disease, and then he would be in on it. His enthusiasm kept him young and hopeful. He always put down for the hopeless things, "I have seen great improvement occur in the treatment of this condition by giving them chloride of gold," but it was expensive, and very few could afford it.

Edward Ochsner still says chloride of gold is good for cancer. In any event I think it should be tried out. I was interested in the papers on cancer which were presented today. How much we have advanced in the last few years in our knowledge of cancer! We are near to knowing the cause of it, and now knowing the contributing causes.

Madison, with its fine schools, fine hospitals, and fine medical men, is a good place in which to live, and in which to educate your children. In reading an article on cancer statistics by Hoffman, I noted that Madison was included among twenty of the large cities of the United States in which deaths from cancer were numerous. Why? I talked to some of the doctors in Madison about it, and they said, "We have the state institutions, and patients are sent here from all over the state and ultimately die here, and the deaths are not credited to the homes of the patients, but to Madison." Then a new viewpoint came to me. Madison should be one of the best places in the United States in which to study cancer since there are so many cases of it here.

I often run across statements about cancer of animals and plants, indicating that wild animals do not have cancer. However, wild animals make a marvelous effort to live at all, and they but rarely reach advanced age. Cancer is not a disease that comes to the young. Only 5 per cent of cases of cancer afflict persons who are aged less than thirty-five years. So, as we save more children for adulthood, more people are living to advanced age, and more and more people are reaching the cancer age.

Sometimes people quarrel with me by saying that this lengthening of life is not one of the signs of the advance of medicine. We are only making more people live long enough to get cancer, they say. They claim that just

* Presented before the 90th Anniversary Meeting, State Medical Society of Wisconsin, Madison, Sept., 1931.

now there is a higher percentage of old people dying than formerly; this is true because there are more of them. What we accomplish by preventive medicine is to make it possible for more people to reach old age, when tissues are subject to degeneration and less resistant to malignant change. Sir Charles Ballance of London, a remarkable surgeon, when he was at the International Conference at Mohawk, New York, said he would guarantee, in regard to all people who live to be a hundred years of age, that he could find cancer in their skin and in regions subject to degenerative changes. According to his belief, if we live long enough we are bound to have types of degenerative conditions some place in or on our bodies.

Plants have cancer. One of the best known plant pathologists was the late Erwin F. Smith of Washington, D. C., who wrote for many years on cancer of plants. I never went to Washington but that I called on him at his greenhouse to see his work with cancer; there was the most perfect cancer as far as typical microscopic appearance is concerned. Death or near death of the plants was caused by the Bacillus tumefaciens which, when injected, was constantly causing destructive chemical processes. If we could think of bacteria only in terms of whether they are toxic, or whether they elaborate something that is good for us, we should conjecture whether the organisms are causing the development of immunity followed by cure, or whether they are destructive, or of certain types that act as stimuli to the body.

At The Mayo Foundation, we have veterinarians who study diseases of domestic animals. They also look after the health of the animals at the Institute of Experimental Medicine, and on the surrounding farms, including my own where many animals are sick with diseases common to them. One of these men has just written a book on "Neoplasms of domesticated animals" which covers the study of 500 tumors found, in the last two years, in animals here and in the stockyards of several large cities. Most of these tumors were malignant or potentially malignant.

I thank the president and officers of the association for the opportunity of speaking to you.

Accessory Patella (Bipartita)*

Duplication of the Patella, a Developmental Anomaly, May Resemble Patellar Fracture and Predispose to Larsen–Johansson Disease

By LEMUEL DAVID SMITH, M. D.
Milwaukee

Duplication of the patella is not an infrequent condition. It has a scientific and economic interest. It is important to differentiate this condition from patellar fracture which it may resemble. Its recognition is essential in a type of "acute knee" in early childhood.

Joachimstal (1), in 1902 was the first to recognize accessory patellae as an anomalous condition and not a fracture in a case of Dr. Natvig of Christiana which showed a transverse fissure separating the patella into an upper and a lower portion. In the same year Rev. Kempson (2), dissecting at Caius College, Cambridge, found in some cadavers and also in some Egyptian specimens an "emargination" of the upper and outer border of the patella. Two years later, Wright (3), elaborated upon emargination and offered an explanation of a separate sesamoid group of cartilage cells in the quadriceps tendon.

It is interesting that about this time, 1903, Osgood (4), described a similar condition in the tibia whereby its tubercle may sometimes be formed by a center of ossification separate from the tongue-like process of the upper epiphysis from which it is usually developed.

Salmond (5), in 1918 noticed the occasional presence of fissures on the outer border of the patella and attributed them to fracture. Todd and McCally (6), in 1921 concluded that these fissures, which may be

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transverse or vertical, represent an anomalous condition and not fractures. Adams and Leonard (7), 1925 are of the same opinion. They find these congenital anomalies in the outer and upper quadrant and as an aid in differentiation state this to be a rare location for fracture. In the series of Joachimstal (1), Wright (3), Todd and McCally (6), etc., and in my series, the location and direction of the fissures vary.

In my series there is one condition of frank fracture of the patella in which the fracture fissure is in the location and direction usually found in the congenital condition. (Fig. 2 Case II). It is a diagonal fissure in the upper and outer border of the patella.

DEVELOPMENT

The patella usually ossifies from one center. It may develop from several centers. These centers may, but do not invariably, coalesce to form one patella. As a variation of accessory patella there is the emarginate patella. The usual form of accessory patella is bipartite with a diagonal fissure in the upper and outer quadrant. It may be multipartite with variable direction, location and extent of fissures.

ROENTGEN EXAMINATION

X-ray examination of painful knee may show a patellar fissure. If there has been a sudden onset associated with accident, diagnosis of fracture suggests itself. It may be a fracture. Location of the fissure in the upper and outer quadrant is not a differentiating factor. Fractures in this region, (Fig. 2 Case II) though rare, also occur. Though the x-ray film may not show it, the bipartite patella is usually larger than normal. It has a roughened border and is thickened and irregular on palpation.

PHYSICAL EXAMINATION

In early youth the bipartite patella may predispose to overstrain of its parts. Such a knee may have increased heat, swelling, redness, and tenderness.

It may simulate acute arthritis, "rheumatism," septic joint or early tuberculosis. This was described by Larsen (8) in 1921 who interpreted it as epiphysitis. It is sometimes found associated with Osgood's (4) disease (apophysitis) of the tibial tubercle and is probably similar in nature. Johansson (9), in 1922 independently described the condition as an unknown lesion of the patella.

TERMINOLOGY

Hawley and Griswold (10), in an enlightening article on the subject suggested the name Larsen–Johansson's disease.

In these cases laboratory findings will be negative. A definite history of injury may be absent. Palpation will probably elicit an irregular patella and accessory centers of ossification in the roentgenogram will aid in diagnosis.

The clinical entity, Larsen–Johansson's disease, may occur in a child too young to register an ossification center of the patella in the roentgenogram (Case VI). Here we must rely upon palpation, elimination, the test of rest of the part and later roentgenograms.

CONCLUSIONS

1. The patella usually ossifies from one center. It may ossify from several centers. The separate centers may or may not unite to form one patella.

2. There is no uniformity in the configuration of the bipartite patella. It may be mono- or bilateral. The location, direction and number of fissures are variable.

3. The location and direction of the fissure in a true patellar fracture is variable. It may simulate an accessory patella.

4. An early bipartite patella may conduce to epiphysitis of the part and produce the symptoms of an "acute knee". This condition may occur in a child too young for the ossification centers of the patellae to register in the roentgenogram.

5. The roentgenogram of a bipartite patella in an individual with a history of injury to the knee may be interpreted as fracture. Palpation usually reveals a patella larger and more irregular than normal. The roentgenogram may fail to do so.

CASE REPORTS

Case I. Edwin K., 32 years old was thrown from a milk wagon rupturing the internal lateral ligament of the left knee for which he was later treated. The duplicate patella was diagnosed as fracture. Figure I shows monolateral accessory patella; left side, one accessory piece is on the upper and outer border.

Case II. John L., age 19, injured his right knee in a foot-ball game. X-ray film showed a fissure in the upper and outer quadrant of the patella. Figure 2 shows a fractured patella on the right side, one fragment is on the upper and outer border. This is an unusual location for a fracture for which he was treated. On x-ray (Figure 3) six weeks later there was complete fusion.

Case III. John K., age 20, fell and injured his right knee, which became chronically painful, swollen and stiff. A diagnosis of tuberculosis was made. Later an x-ray examination revealed a fissure in the upper and outer quadrant of the patella and diagnosis of patellar fracture was made. The patient later improved under treatment for injury of the internal semi-lunar cartilage. Figure 4 shows monolateral accessory patella, right side, one piece on the upper and outer border.

Fig. 1. Roentgenogram of monolateral accessory patella, left side, one accessory piece is on the upper and outer border.

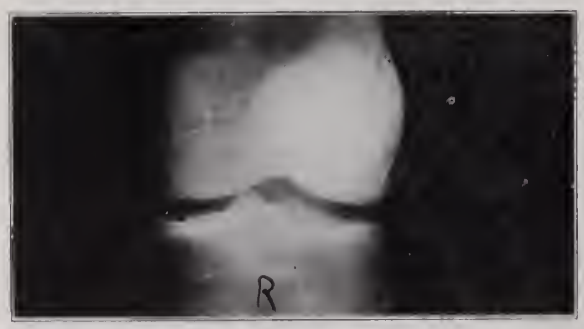

Fig. 2. Roentgenogram of fracture patella, right side, one fragment is on the upper and outer border.

Fig. 3. Healed.

Case IV. Emil W., age 15, was a tall, rapidly growing boy who complained of pain, swelling and stiffness in the left knee. There was no history of injury. X-ray examinations revealed apophysitis of the tibial tubercle with patellar emargination. Rest and protection removed the symptoms. Figure 5 shows monolateral emarginate patella, left side. The irregularity is on the upper and outer margin. Osgood's[1] disease left tibial tubercle, Larsen[8] – Johansson's[9] disease.

Fig. 4. Roentgenogram of monolateral accessory patella, right side, one piece is on the upper and outer border.

Case V. Anna D., age 47, presented a "chronic knee". It was not swollen. There was no increased heat, joint tenderness nor limitation of motion. The left patella was freely movable and twice the diameter of the right, irregular and rough. There have been, at widely separated intervals, three independent diagnoses of fracture of the patella. It is potentially weak and is subject to frequent strain. Figure 6 shows mono-

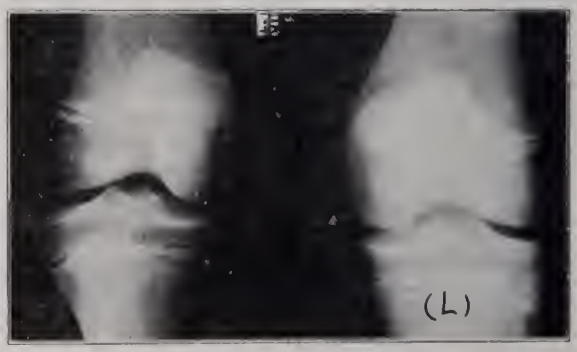

Fig. 5. Roentgenogram of monolateral emarginate patella, left side; the irregularity is on the upper and outer margin. (Larsen–Johansson's disease.)

Fig. 6. Roentgenogram of monolateral accessory patella consisting of five pieces, left side. (Larsen–Johansson's disease.)

lateral accessory patella, left side consisting of five pieces. Larsen[8]–Johansson's[9] disease (old).

Case VI. Marilyn G., age three and one-half years. The right knee was swollen, not tender but with moderate redness. The joint was held extended and flexion was resisted. The right patella was larger than the left, and somewhat nodular. There was no history of injury. The symptoms had gradually increased the preceding month. Otherwise she was normal. Laboratory findings were not significant. X-ray examination was negative. The ossification centers were not formed. The patellae were not seen on the film. The knee was put at rest and the symptoms promptly subsided. Figure 7 shows monolateral accessory patella, right side, with transverse fissure, Larsen[8]–Johansson's[9] disease. A roentgenogram one year later showed two ossification centers in the right patella, one above the other.

Case VII. Daniel S., 8 years, walked with a limp and the left knee flexed for a month. There was no history of injury. The patient did not appear ill. There was increased heat in the knee. There was no swelling nor tenderness. The patella was freely movable. It gave the impression of slight roughness and irregularity. A tentative diagnosis of bipartite patella with potential Larsen[8]–Johansson's[9] disease made. Rest and protection relieved the symptoms. Roentgenograms revealed bilateral bipartite patella, similar to Figure 1, Case I, but bilateral; bilateral accessory patellae of the more frequent type, one extra piece in each upper and outer border, Larsen[8]–Johansson's[9] disease.

Case VIII. Anna Z., age 8 years, had an acute onset of anterior poliomyelitis in June, 1931. She was adequately treated. There are no paralytic sequellae. The later complaint in October, 1931, was pain and weakness in the knee. The knees appeared normal. The patellae were smooth but were some-

Fig. 7. Roentgenogram of monolateral accessory patella, right side, with transverse fissure. (Larsen–Johansson's disease).

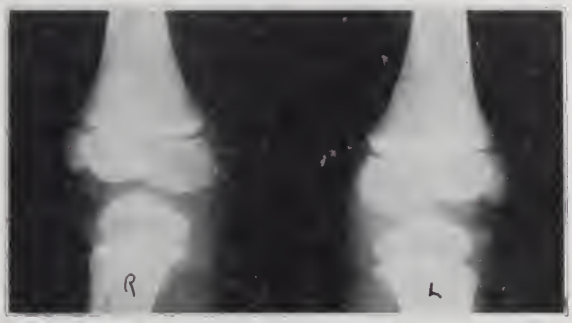

Fig. 8. Roentgenograms of bilateral accessory patellae with transverse fissures separating the lower poles from the main bodies (Larsen–Johansson's disease).

what larger than one would expect for the individual. They were freely movable; one felt a hyperflexibility of them in the flat plane. A tentative diagnosis of bilateral bipartite patella with incipient epiphysitis was made. Roentgenograms revealed separate lower poles in each patella. Figure 8 shows bilateral accessory patellae, with transverse fissures separating the lower poles from the main bodies, Larsen–Johansson's.

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Gas Gangrene; Some Observations on the Diagnosis and Treatment of Gas Gangrene Complicating Compound Fractures*

By JOHN O. DIETERLE, M. D.
Milwaukee

The development of gas gangrene in a compound fracture is fortunately a rare occurrence in civilian practice. The disease usually catches the physician off guard and one may consider himself fortunate in the treatment of wounds to have escaped the disastrous consequences of this complication. Keen stated that up to 1918 he had seen but one case. Pickard of Kansas City in 15 years of rail-road surgery had treated only three cases. Review of the literature reveals that gas gangrene occurs extensively in nearly all wars. The Boer War was a noted exception, the explanation for which can undoubtedly be ascribed to the non-fertilization of African soil. The disease was first described by Maissoneuve in 1853 and one year later Saleron reviewed 65 cases in material taken from the Crimean War. Its cause was unknown until Pasteur's discoverey of vibrion septique in 1876. In 1881 Koch and Gafky announced the discovery of the bacillus of malignant oedema. Molier and Ponget were the first to use the term gas gangrene in 1882. In 1892 Welch and Nutall isolated bacillus aerogenes capsulatus (also called bacillus Welchii or perfringens) which is the more common and malignant of the gas-forming anaerobes. Fraenkel independently sustained this discovery one year later.

The largest series of civilian cases collected in this country are those by Welch (46 cases), Cramp (187 cases), Simonds (175 cases), and the important series of 85 cases by Weintrob and Messeloff. In the latter the authors analysed the admissions of 15 years to Belleview Hospital, N. Y., and found one case of gas infection to every 7310 patients. An analysis of all the above series shows that about 30% of the cases occurred in compound fractures.

Classical descriptions of the disease may be found throughout the literature. The insidious onset with increasing pain and high pulse rate two or three days after injury, the rapid course, varied color changes in skin and muscle with gas infiltration, the foul, musty odor and characteristic chocolate brown discharge constitute an unmistakable picture. In one of my cases in which the leg became greatly distended, gas could be heard escaping at intervals from the wound and from areas of skin nearby.

No important advances in the prophylaxis and treatment of gas gangrene were made until the World War when the general management of wounds and the development of a serum paved the way. With a knowledge of its pathological anatomy the surgical treatment of gas infection became more than mere guess work. It is most enlightening to read the reports of the British Medical Corps and in particular those of Wallace. All authors are agreed on the gross pathological points as laid down by him in the British Medical Journal in 1916. The most important are as follows:

1. Gas gangrene is always a muscle disease and advances longitudinally, confining itself in the early stages to one muscle or to a group of muscles.

2. If pressure of fluid and gas is not relieved death takes place by strangulation.

3. Muscles confined in rigid compartments like the tibialis anticus become gangrenous rapidly.

4. The infection is always further advanced in muscle than in the intermuscular planes.

5. Crepitation is a late occurrence and is

* Presented before 90th Anniversary Meeting, State Medical Society of Wisconsin, Madison, Sept. 1931.

due to the escape of gas into areolar and subcutaneous tissues.

In 1917 Frankau, Drummond, and Nelligan of the British Army reported success in the conservative surgical treatment of early cases based on the facts enumerated by Wallace. They were able to save or conserve limbs by resecting single muscles or groups of muscles, observing that the resection should extend up to where the muscle has a normal appearance and where its contractility and free bleeding are assured. In some cases they removed entire muscles from origin to insertion.

The use of serum for prophylaxis and treatment was first instituted during the World War. Sacquepee of the French army treated 190 cases of proven gas bacillus infection with the polyvalent serum of Leclainche and Valle, recording a mortality of 13% in contrast to a 75% mortality in a controlled series of non-treated cases. A combined serum consisting of the antitoxins of bacillus Welchii, vibrion septique, and tetanus is now used for prophylaxis and therapy and there can be little doubt that in combination with a rational surgical treatment the occurrence, morbidity, and mortality of gas gangrene will be greatly reduced.

The following points should be observed in preventive treatment:

1. Thorough debridement in all severe compound fractures.

2. Small pieces of muscle may be dropped into culture media. If gas develops the physician will be on guard for any beginning signs and symptoms of the infection. A positive culture denotes presence of anaerobes and not necessarily the disease.

3. Prophylactic doses of the combined serum (50 cc. every 12 hours) should be given at once. The usual precautions should be taken to prevent anaphylactic shock.

4. Irrigation of the wound, preferably with Dakin's solution, certainly lessens the chance for the infection to gain a foothold.

5. Splintage must be adequate and still be so arranged to allow frequent inspection of the wound. Dressings should be sparingly used if at all. In this connection it might be wise not to fill the wound with vaseline and encase the limb in plaster until the incubation period of gas infection has passed.

When the infection has definitely developed, multiple incisions extending through the deep fascia might be sufficient to arrest its progress. To be on the safe side, however, it is best to do an immediate dissection, resecting any necrotic muscle tissue. In this way only can one be reasonably sure of localizing the disease. In advanced cases the limb must be sacrificed to save life. Therapeutic doses of serum are injected into the wound and surrounding tissues in 100 cc. doses every 6 to 12 hours as the case may demand until a favorable reaction ensues.

Recurrence of gangrene in an amputated stump does not denote contamination by faulty technique but means that the operator did not get above the line of demarcation in the gangrenous muscles. In advanced cases it may be impossible to get above areas of crepitation when a high amputation with lateral slashing of the stump must suffice.

Because of infection and sloughing, a guillotine amputation is the usual procedure. Mention might be made that much disagreeable after treatment will be spared by resecting bone 1½ to 2 inches above the level of soft parts and by leaving large flaps of skin hanging on the end of the stump for later plastic repair.

CASE REPORTS

Case 1

A mechanical engineer, age 28, was admitted to Mt. Sinai Hospital on Jan. 25, 1931, after a severe injury to the right leg. Examination showed a compound comminuted fracture of the tibia and fibula in the middle third. There was extensive deep laceration of the calf muscles. The external wound appeared quite innocent until a foul, musty discharge, with development of gas in the tissues on the third day after injury, changed the entire picture. Cultures from the discharge showed growth of gram-positive, spore-forming rods, anaerobic in type, producing abundant gas. The predominating organism was defined as the Welch bacillus by Dr. N. Enzer. The entire leg became greatly distended, so much so that gas could be heard escaping from the wound. A guillotine amputation was advised as a life saving measure. This was done at mid-thigh; the stump was then slashed radially through the upper facial layers nearly to the groin. While the amputation was being done, a 1000 c.c. whole blood transfusion was done by Dr. R. E. Morter. Anti-gas gangrene serum was injected into the stump in 100 c.c. doses every 6 hours.

Death appeared a certainty, but patient responded favorably and was considered out of danger in 24 hours. In reviewing the literature, little comment is made on the hemolytic properties of certain types of gas-producing organisms. In this case there was intense hemolysis and transfusion was necessary on alternating days for a week following amputation. Notation was also made of the persistence of islands of crepitation as high as the iliac crest for several days following amputation. The stump was finally healed after minor plastics covering a period of several months, and patient is now getting about on an artificial leg.

Case 2

A moulder, age 35, injured on July 19, 1931, entered the Soldiers' Home Hospital on July 21, 1931, with a compound fracture of left os calcis, compression fractures of the first and second lumbar vertebrae, comminuted fracture of the right tibia and fibula just above the ankle, and multiple fractures of the pelvis. Examination of the left foot on en-

trance showed moderate swelling, severe pes planus, and a compound comminuted fracture of the os calcis, with a punctured wound on the plantar surface. There was also superficial crepitation of the skin and a greenish discoloration and brownish, foul discharge. On removal of a gauze pack there was escape of gas. Incisions were made through the gangrenous area and radially around the foot and leg. (See photograph.) 10,000 units of gas serum were given intravenously by Dr. J. Regan. The discharge was cultured and defined as Welch organism by Dr. Enzer. The following notes reveal the progress of the case:

July 22—Examination showed extension of the gangrene. 10,000 units of serum given at 10 A. M. Pulse 102, temperature 101.2. General condition poor. Patient taken to operating room and left leg was dissected up to knee. All of the anterior groups were found necrotic. Posterior groups showed healthy looking muscle. Amputation was done 4" below the knee by guillotine method.

At 7:00 P. M.—500 c. c. of citrated blood.

At 10:00 P. M.—10,000 units of serum.

July 23—General condition poor. 2000 c.c. glucose solution intravenously at 10:00 A. M. 10,000 units of serum at 4:00 P. M.

July 24—same treatment—condition poor.

July 25—10,000 units of gas serum given intravenously with favorable reaction.

July 28—Patient developed delirium tremens. After a stormy time he gradually recovered.

The accompanying x-ray pictures show comminuted fracture of the os calcis and islands of gas in the soft parts of the instep and along the anterior tibial muscles. Note absence of gas infiltration in the posterior part of the leg, corresponding to the operative findings.

THE JOURNAL CLINIC

Tularemia

By W. J. TUCKER, M. D.
Ashland

Search of the literature on tularemia has not revealed any reports on the hemolyzing action of the blood of these patients. The necessity that may arise at times of transfusing patients with tularemia makes this question of vital importance. The disease seems to be endemic in the northern part of the State and is not infrequently seen. The following case exemplifies a unique phase of the disease:

E. B., age 18, had skinned a wild rabbit one week previous to onset of disease. He had an abrasion of the finger of right hand at the time. He was taken with a chill, temperature and developed redness, swelling and tenderness about lesion on hand. Within 48 hours the glands in axillary space became tender and swollen. Temperature ranged from 102 to 106F. Patient was quite prostrated and looked extremely ill. R. B. C. 4,690,000; W. B. C. 9,400; Hg. 90%; Color Ind. .9; Polymorphonuclears 83%; Lymphocytes 12%; Transitionals 5%. A positive agglutination reaction for tularemia was found at the State Laboratory. With the intention of stimulating resistance a transfusion was decided upon. Patient was found to be in Group II. Twenty-four donors were tested and the blood of each was hemolyzed and agglutinated by the blood of the recipient. We were unable to find a suitable donor. Naturally, no transfusion was done. We were unable to find any record of similar report. The patient eventually recovered after five weeks. His blood has been grouped since, 2 months after, and found to react normally as the blood of a Group II donor should. There was no agglutination or hemolysis in the blood of several of Group IV and Group II donors used.

A communication from the Public Health Dept. U. S. states that no such observations have been made in their experience. A letter from the Wisconsin State Laboratory at Madison also states that they have no record of any such hemolyzing effect of the blood of tularemia patients. While such a blood reaction may not be common in this disease and may have been purely distinctive of this patient, it should be kept in mind, for circumstances may well arise that would make a transfusion advisable.

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EDITORIALS

SIDNEY STORRS HALL

DOCTOR Sidney Storrs Hall, for thirty-five years Treasurer of the State Medical Society of Wisconsin, and former President, who practiced his profession in Ripon for forty-two years, passed away on May 7th in Minneapolis, where for the past seven years he has made his home with his daughter, Miss Jennie Hall. Until a few months ago Doctor Hall had enjoyed unusually vigorous health and his last illness was of short duration.

He was the son of Doctor and Mrs. Storrs Hall and was born at East Bloomfield, New York, on March 1, 1844. His parents came to Rosendale when he was seven years of age, and with the exception of eight years spent in Morrison, Illinois, he was a resident of this state until 1924, when he retired from active practice and made his home with his daughter in Minneapolis.

Doctor Hall was a graduate of the Medical School of Harvard University, completed his course in 1867, and when in reminiscent mood delighted in recalling his student days under Oliver Wendell Holmes. Following his graduation he was associated in practice with his father in Rosendale for two years, practiced at Sheboygan five years, and for a short time at Morrison, Illinois, before locating at Ripon. He was a veteran of the Civil War, entering the service of the United States Navy as a surgeon steward and serving on "The Cricket", a gun-boat of the Mississippi squadron throughout the war.

On July 14, 1868, Doctor Hall was united in marriage to Frances S. Powell at Rosendale. Her death occurred in 1902 as did that of a son, Doctor John Storrs Hall.

It is no exaggeration to state that Doctor Hall was probably the most loved man identified with Wisconsin medicine at the time of his death. He had given a life time of devotion to the State Medical Society, and, together with the late Doctor Charles Sheldon of Madison, guided the destinies of the organization for a quarter of a century. It is difficult indeed to write a better tribute to him than was given by Doctor Silas Evans, President of Ripon College, who officiated at the funeral services:

"We gather this afternoon in token of esteem and affection for Dr. Sidney Storrs Hall, whom this community holds in high regard as a worthy citizen and Christian gentleman. We are here to acclaim our testimonial to Dr. Hall, as a man dedicated to the healing service, a man of high professional dignity, a man greatly honored by his professional colleagues; a counselor whose advice was governed by respect for facts, rather than caprice or prejudice; a man exacting and vicarious toward people and causes, a man of discrimination in his judgment of things and men, broad and generous in his sympathy; a leading citizen of no mean city, who

bore a generous measure of responsibility, a good citizen whose activities were shot through and through with worthy motives.

"As citizens and friends and family beloved, I ask that we rise to our feet in a token of high respect. (Congregation rising.)

"Dr. Sidney Storrs Hall, whose presence is sufficiently felt, whose eyes may be withholden with larger and better vision, we are extending to you in this service a toast from the friends living to a friend living more abundantly. * * *

"It is appropriate that this service be held here as a community service. Dr. Hall's father was a physician, serving for many years at Rosendale. Dr. Hall served this community for forty-two years. Anyone who knows the community, knows Dr. Hall; and we all know very well what a good doctor means to all of us.

"We recall when boys in the district schools, we used to try to "leave our mark" on fence posts, cut into birch trees or old barn doors. It was a bit of boyish mysticism, an instinctive outreach of the young soul to perpetuate the knowledge of its existence upon this forgetful earth. But in a deeper and more genuine way, Dr. Hall has left his mark on this community, as is true of every good doctor. The mystic sign is deep-lettered, particularly upon the hearthstones of our homes. He served here among these hills and prairies. For forty-two years he was among us as one that served. He knew every nook and crevice of the beloved community; at first wearing out horses, and then autos, as day and night, summer and winter, he went in and out among us. He brought many into the world, and attended many in their passing.

"To one who is only impressed with outward excitements the story has no great appeal. The life of a small town physician may seem barren and unfruitful. Often great service does seem barren and unfruitful, but I want to say that it is a great triumph to grow old and merit respect. People are pretty well known in a community like this. A stranger may come in and deceive us. This is often done. But friends who live among us cannot easily deceive us.

"Dr. Hall was a student to the end of his days. There was a certain delightful brusqueness about him which frightened those who knew him not very well. Knowing him better we found him to be gentle and thoughtful. * * *

"Dr. Hall was in the ministry of relieving pain and curing bodily ills, and he was constantly telling people what they knew deep down in their hearts to be true. He hated sentimentality and loved sentiment. He that is greatest among you, let him be as one that serves." R. S.

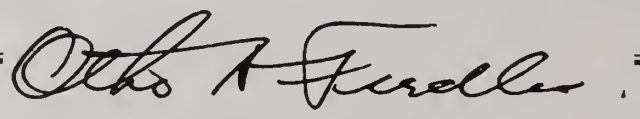
VITAMIN D MILK

THE possibilities of adding to or increasing the antirachitic vitamin content of foods has stirred the interest of the profession and the public since the early work of Steenbock with irradiated ergosterol. Subsequent experimentation has shown that the feeding of irradiated yeast to cows produces a milk with definite antirachitic potency.

The many advantages of this method of administering vitamin D has led to commercial projects for the production of such milk in several large centers of population. Fortunately, commercial production and distribution will be supervised by licenses from the Wisconsin Alumni Research Foundation. This Foundation will prescribe the conditions under which this milk can be produced and will attempt to maintain a constant vitamin potency. At the present time such supervision is quite complicated and expensive, but it is hoped that methods for more expeditious analysis will soon be evolved. The Foundation insists on regarding commercial production at the present time as experimental, and licenses issued thus far merely state that producers of such milk are licensed by the Wisconsin Alumni Research Foundation.

The future of this method of supplying vitamins would seem promising, but a cautious and well controlled exploitation has fortunately been insured by the supervisory powers of the Foundation. Furthermore, thus far licenses have been issued only to producers of certified milk operating under the jurisdiction of local medical milk commissions. J. H.

THE PRESIDENT'S PAGE



"CONCERTED ACTION"

A LITTLE consideration leads one to the conclusion that the medical profession is really much more actuated by social than by individualistic motives. This is the more strange, since, through his training, every physician becomes an individualist, self reliant and self sufficient so far as his work is concerned. However, he is always actuated by altruistic motives and his interests are much more humanitarian than materialistic, probably because of his human contacts. As a result, physicians are imbued with a very definite and compelling social consciousness. The doctor does not for a moment think of himself or his own well-being in an emergency. He is ever ready to take, so far as he himself is concerned, severe chances to relieve suffering and to restore his patient. He has always been ready to go to the most dangerous areas of the battlefield. Often, at the sacrifice of life, he has searched for and conquered the invisible enemies of mankind.

From a commercial point of view he is the one individual who does not exploit his discoveries for material gain. A long succession of medical practitioners and medical research workers numbering thousands, who could have profited materially from their discoveries, gave them freely to mankind and thereby have added years of happiness and life itself to millions of people.

Again, the doctor is the only individual who is working constantly to eliminate from the environment of man those conditions in the management of which, and those diseases in the treatment of which he gains his livelihood. There is hardly a physician who is not fully as interested in preventive as in curative medicine. While the work of the practitioner is actually in relief or cure of the individual, still he attempts constantly to educate and guard society so that no individual shall need his services either as diagnostician or healer. In his official organizations he is constantly spending his time and money in an endeavor to educate the people and to give them that information which will obviate the necessity of their employing his services.

Finally, in the social body he has, from time immemorial, voluntarily assumed responsibility for care and treatment of all of those unfortunate members of society who could not provide for themselves in accident and illness, the services which they needed but could not pay for. The survey recently conducted by the County Medical Society of Kent County, Michigan, which includes the city of Grand Rapids, revealed that each physician in that area rendered daily a gratuitous service the average value of $6.00, or approximately $1800 a year. That was also about the average for Milwaukee County in 1931. The President of the Milwaukee County Medical Society informed me that for the current year it will be almost twice that amount. Personal experience corroborates these figures for a free service in other communities.

What must be evident is that while the profession must go on doing as it has ever done, giving to mankind its discoveries, continuing its work in preventive medicine and public health, and pursuing its educational program to diminish the incidence of illness and accident, it can not continue to extend more and more gratuitous service, for there must come a time when such procedure will result in disintegration of the profession. We need closer organization for the study of this problem and to obtain concerted action which shall safeguard the material interests of the physician so that he can continue his humanitarian social program for the conservation of the vital resources of the nation in the education of the masses, the pursuit of research work, and the relief of the suffering and illnesses of his fellow man.

But such ends can be attained only as he works in cooperation with his colleagues, and this emphasizes at once his obligation to actively participate in the established official bodies of the medical fraternity, and he must maintain active membership in national, state, and county organizations if he is to maintain himself and his profession and render the greatest service to the general public.

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Lafayette	R. B. Quinn, Darlington	W. B. Williams, Argyle.
Langlade	C. E. Zellmer, Antigo	J. C. Wright, Antigo.
Lincoln	F. L. Kelley, Merrill	W. H. Bayer, Merrill.
Manitowoc	C. H. Barnstein, Newton	E. C. Cary, Reedsville.
Marathon	Joseph F. Smith, Wausau	Verne E. Eastman, Wausau.
Marinette-Florence	T. J. Redelings, Marinette	C. H. Boren, Marinette.
Milwaukee	P. M. Currer, Milwaukee	Theo. Wiprud, Ex. Sec'y, Milw
Monroe	A. E. Winter, Tomah	H. H. Williams, Sparta.
Oconto	R. J. Goggins, Oconto Falls	G. W. Krahn, Oconto Falls.
Oneida-Forest-Vilas	C. D. Packard, Rhinelander	I. E. Schiek, Rhinelander.
Outagamie	E. F. Mielke, Appleton	R. V. Landis, Appleton.
Pierce-St. Croix	H. P. Conway, Spring Valley	A. E. McMahon, Glenwood City
Polk	L. O. Simenstad, Osceola	Geo. B. Larson, Frederic.
Portage	F. A. Marrs, Stevens Point	H. P. Benn, Stevens Point.
Price-Taylor	F. W. Mitchell, Medford	G. L. Baker, Westby.
Racine	C. O. Schaefer, Racine	Susan Jones, Racine.
Richland	W. C. Edwards, Richland Center	G. Benson, Richland Center.
Rock	G. S. Metcalf, Janesville	E. C. Hartman, Janesville.
Sauk	Roger Cahoon, Baraboo	A. C. Edwards, Baraboo.
Shawano	C. E. Stubenvoll, Shawano	L. W. Peterson, Shawano.
Sheboygan	H. F. Deicher, Plymouth	A. C. Radloff, Plymouth.
Trempealeu-Jackson-Buffalo	R. L. Alvarez, Galesville	R. L. MacCornack, Whitehall.
Vernon	W. M. Trowbridge, Viroqua	Wm. H. Remer, Chaseburg.
Walworth	S. G. Meany, East Troy	V. S. Downs, Lake Geneva.
Washington-Ozaukee	O. J. Hurth, Cedarburg	P. M. Kauth, West Bend.
Waukesha	J. C. Hassall, Oconomowoc	J. F. Wilkinson, Oconomowoc.
Waupaca	R. K. Irvine, Manawa	F. J. Pfeifer, New London.
Winnebago	G. E. Forkin, Menasha	M. C. Haines, Oshkosh.
Wood	F. X. Pomainville, Wisconsin Rapids	W. G. Sexton, Marshfield.

SOCIETY PROCEEDINGS

BROWN-KEWAUNEE

One of the largest meetings of the year was held by the Brown-Kewaunee County Medical Society on April 28th at the Hotel Northland, Green Bay, when Dr. Irving S. Cutter of Chicago presented a paper on "The Future of the Practice of Medicine." About one hundred physicians were in attendance including many from the neighboring cities.

W. E. M.

CHIPPEWA

A meeting of the Chippewa County Medical Society was held at Hotel Northern, Chippewa Falls, on Tuesday, May 10th, at six-thirty o'clock. Twenty-two members were present.

The program consisted of the following papers:

"Adenomatous Goiter" by Dr. Austin C. Davis of the Mayo Clinic.

"Chronic Fevers" by Dr. J. M. Berkman, also of the Mayo Clinic.

FOND DU LAC

The following resolution was adopted by the Fond du Lac County Medical Society at a meeting on February 19th:

"Whereas: The government of the United States has, by legislation, increased the number of ex-service men privileged to hospital care at Federal expense and

"Whereas: The present government hospital capacity being insufficient for the accommodation of the great increase of patients resulting from the enactment of laws relative to hospitalization of ex-service men for diseases not connected with military service and

"Whereas: The cost of new hospital buildings to the government having been estimated at approximately $360,000,000; and administration and maintenance costs requiring $219,000,000 annually; and the fact that the projected hospitals would be used for but a few years and then probably abandoned; and the long travel from their homes of service men to government hospitals for treatment for diseases not connected with service, would be uncertain, inconvenient, and at times hazardous, and not favored by the majority of service men; and the cost, constituting a treasury raid at a time when economy in government should be a patriotic purpose and

"Whereas: The cost of this same service in civilian hospitals where there are sufficient beds which can be secured by direct government aid to the individual service man, enabling him to seek treatment in civilian hospitals with his own choice of physician, which is his own American privilege; and

"Whereas: The direct aid to the ex-service man can be secured as efficiently for an estimate cost of $92,000,000 per year, which would cover hospital service, and a weekly cash payment of $20.00 to his family, without the expenditure of vast sums for hospital construction and

"Whereas: All these considerations operate to make this direct aid plan preferable in every particular, with reference to cost, convenience, and character of service, to the bureaucratic un-American program now proposed in many quarters for treatment of diseases not related to service.

"Now, Therefore Be It Resolved, That the sense of the Fond du Lac County Medical Society is that the direct aid plan is in all ways superior, besides constituting a patriotic duty and

"Be It Further Resolved, That a copy of this resolution be sent to ex-service men's organizations, senators, representatives, officers of state medical society, county medical societies, and other organizations concerned with bettering governmental relation with ex-service men."

FOND DU LAC COUNTY MEDICAL SOCIETY,
JOHN C. YOCKEY, M. D.,
President,
HARVEY R. SHARPE, M. D.
Secretary.

GREEN LAKE-WAUSHARA-ADAMS

The Green Lake-Waushara-Adams County Medical Society held a regular meeting at the Hotel Chase, Wautoma, on April 26th. It was a joint meeting with the Wautoma Lions Club.

Dr. Otho A. Fiedler, Sheboygan, was the principal speaker of the evening. His subject was "Heart Diseases."

KENOSHA

The Kenosha County Medical Society met on Tuesday evening, May 24th. Dr. T. M. Trau of Chicago spoke on "The Clinical Manifestations of Thyrotoxicosis" and Dr. Harry M. Richter of Chicago discussed the "Surgical Treatment of Thyrotoxicosis". W. H. L.

LA CROSSE

The La Crosse County Medical Society held its annual banquet and meeting at the Oak Forest Sanatorium, Onalaska. The banquet and dinner was well attended. Many physicians from neighboring towns attended.

Dr. Edyth Swarthout, La Crosse, was in charge of the program.

Dr. James Evans, La Crosse, presented a paper, illustrated with slides on "Tuberculosis Surgery at St. Michael Orphanage."

Dr. Martin Sivertson, La Crosse, gave a case report on "Lung Abscess" illustrated with x-ray films.

Dr. Edyth Swarthout presented a paper on

"Phrenic Exeresis" illustrated with x-ray films while Dr. M. A. McGarty discussed the surgical technique.

Dr. McGovern, dentist, discussed dental care at the Sanatorium. A general discussion followed. Meeting adjourned. G. D. R.

MARINETTE–FLORENCE

The Marinette–Florence County Medical Society held its regular monthly meeting at Hotel Menominee April 21st. Dinner was served at six-thirty o'clock. Eighteen members were present.

A symposium on peptic ulcer constituted the program:

"Medical Diagnosis of Peptic Ulcer" by Dr. E. M. Jordan of Green Bay.

"X-Ray Diagnosis of Peptic Ulcer" by Dr. R. L. Troup of Green Bay.

"Surgical Treatment of Peptic Ulcer" by Dr. C. S. Williamson of Green Bay.

Dr. Ralph Carter of Green Bay was a guest at this meeting.

Groups of nurses from St. Joseph's and the Marinette and Menominee hospitals were present during the scientific program. The program was interesting and instructive. T.J.R.

MILWAUKEE

The May dinner meeting of The Medical Society of Milwaukee County was held jointly with the Milwaukee County Dental Society at the Hotel Pfister on May 20th.

Reports were made by Dr. S. J. Seeger, chairman of the social medicine and medical economics committee, and Dr. James C. Sargent, chairman of the special medical advisory committee to the Milwaukee Real Estate Board, on the activities of their committees which are considering important economic aspects of medical practice in Milwaukee County.

Dr. Seeger reported that about 300 schedules on contract and panel practice in Milwaukee County had been returned, and urged those who had not filled out the questionnaire and returned it to do so promptly.

Dr. Sargent commented on the progress made by his committee, whose members are Drs. Sargent and S. J. Seeger, and Mr. Theodore Wiprud, ex-officio member, in its cooperative work with the Milwaukee Real Estate Board in the study of public health services sponsored by the county and city governments.

A program was presented, following the dinner, with Dr. George W. Wilson, President of the Milwaukee County Dental Society, and Dr. Vilray Papin Blair, professor clinical surgery, Washington University Medical School, and professor of oral surgery, Washington University School of Dentistry, St. Louis, as the speakers.

Dr. Wilson spoke on "Medical–Dental Relations."

Dr. Blair's subject was "Surface Repairs for Both Function and Appearance." His talk was illustrated with lantern slides and motion pictures.

Dr. Blair's presentation was discussed by Drs. S. J. Seeger, M. N. Federspiel, and W. H. Halsey.

There were about 200 present for the program.

OUTAGAMIE

"Medical Economics" was the subject of an address by Mr. G. E. Bond, business manager of the Sheboygan Clinic, before the Outagamie County Medical Society at Hotel Kaukauna, April 19th. Thirty-five physicians attended the dinner and meeting.

At this meeting, the Society voted to set up a permanent baby welfare committee which will supervise all clinics and activities connected with infant welfare.

POLK

The attorneys and high school principals were the guests of the Polk County Medical Society on April 21. The meeting was held in Frederic, with Drs. Arveson and Diamond as hosts. The purpose of the meeting was to develop a closer professional feeling within the County. The speakers were Mr. Tom Vennum, Minneapolis, who spoke on "The Responsibility of the Educated Man to His Community" and Mr. Clarence Hartley, president of the Wisconsin Bar Association, who discussed "The Organized Bar".

School doors opened once again for the members of the Polk County Medical Society on May 19th, at the Hickory Point, Amery, Wisconsin. A series of case histories were mailed to each member who was advised to come to "class" prepared to recite. The diagnosis and treatment was kept by the Secretary and after each recitation the correct diagnosis and treatment was given.

A report of the progress of the "Child Health Survey" was given by Dr. Riegel. The Committee appointed stated that they had secured $300 from the County Board to finance the supplies, postage and clerical work connected with the survey.

The communication relative to Wisconsin General was read before the Society and the following motion was adopted: "That each member be instructed to make a complete history of all cases sent to Wisconsin General Hospital that they thought were an unjust charge against the county and the state." All such cases were to be mailed to the Secretary and then to the committee appointed by the State Medical Society to investigate such cases.

Motion was made and seconded that Drs. Wm. B. Cornwall, L. O. Simenstad, and J. A. Riegel be appointed a committee to arrange a fracture short course. Carried.

Motion was made and seconded that the Polk County Medical Society make a percentage division of the money received from the County for the care of the indigent sick. Carried. G. B. L.

RACINE

The regular meeting of the Racine County Medical Society was held at the Racine Elks Club, Thursday evening April 21st at eight o'clock.

Dr. William J. Dieckmann, University of Chicago, gave a talk on "Toxemias of Pregnancy." Dr. Phil A. Daly of the Heart Clinic, Lying-In Hospital, Chicago, spoke on "The Heart in Pregnancy, (Illustrated)." Dr. W. C. Danforth, Evanston, Illinois, gave a talk on "The Treatment of the Occiput Posterior Position." (Illustrated).

The May meeting of the Society was held at the Racine Elks Club on Thursday evening, the 5th, at eight o'clock.

Dr. William F. Braasch, head of the section on urology, Mayo Clinic, gave a talk on "Infections of the Urinary Tract and Their Treatment."

Dr. James C. Sargeant, Milwaukee, gave a talk on "New Operation with Primary Closure of the Bladder." S. J.

WINNEBAGO

Dr. Simpson M. Markson, clinical professor of dermatology Marquette University School of Medicine, presented slides showing the common types of skin diseases and discussed their treatment before a meeting of the Winnebago County Medical Society at the home of Dr. Donald G. Hugo, Oshkosh, on April 21st.

MILWAUKEE ACADEMY OF MEDICINE

Members of the Milwaukee Academy of Medicine met on May 17th for a dinner and business meeting at Milwaukee County Hospital. This was followed by the scientific meeting.

Dr. Harry Beckman, Milwaukee, gave a presentation of cases, specimens and roentgenograms on "The Acid Treatment of Hay Fever."

Dr. George E. Brown of the department of medical education and research of the Mayo Clinic, spoke on "Recent Experimental and Clinical Work on Blood Pressure."

SEVENTH COUNCILOR DISTRICT

Members of the Seventh Councilor District Medical Society held their eighth annual meeting in La Crosse on April 27th. Surgical and medical clinics were held during the forenoon at the local hospitals with demonstrations of cases while the afternoon and evening programs were conducted at the Stoddard Hotel.

The program follows:

Grandview Hospital: (Dr. N. P. Anderson, Chairman Committee) Surgical Treatment of Acute Mastoiditis, R. L. Eagan, M. D.; Factors in Hospital Organization to Meet Requirements of Depression, W. A. Henke, M. D.; Eclampsia, B. W. Mast, M. D.; Uremia, N. P. Anderson, M. D.; Laboratory Procedure, F. N. Nimz, M. D.

La Crosse Lutheran Hospital In Association with the Gundersen Clinic: (Dr. Gunnar Gundersen, Chairman, Committee) Operative Clinics by members of the staff. Dry Clinics. Exophthalmic Goitre in Children, Demonstration of cases, S. B. Gundersen, M. D.; Acute Surgical Mastoiditis, E. C. Smith, M. D.; Demonstration of Transurethral Resection of Prostate, A. H. Gundersen, M. D.; Skull Fracture, P. C. Gatterdam, M. D.; Medical Treatment of Lung Abscess, M. Sivertson, M. D.; Management of Labor, E. S. Carlsson, M. D.

La Crosse Hospital: (Dr. Walter Jones, Chairman Committee) Operative Clinics by members of the staff. Undulant Fever, with case report, G. R. Reay, M. D. and G. D. Reay, M. D.; Sympathetic Ophthalmia, with case report, F. A. Douglas, M. D. and L. W. Eidem, M. D.; Operative Treatment of Pulmonary Tuberculosis, with case report, E. C. Swarthout, M. D.; Various Types of Fractures of the Upper One-third of the Humerus with Treatment and Results, W. J. Jones, M. D.; Case Report of Pulmonary Malignancy Secondary to Warts, with Postmortem Findings, J. E. Heraty, M. D.; Case Report of Pulmonary Malignancy, H. A. Jegi, M. D. and R. Alvarez, M. D.; Case Report of Acute Rheumatic Fever in Child Three Years of Age, L. Hanson, M. D. At the luncheon, Mr. L. F. Robinson talked on "The Cockeyed World."

St. Francis Hospital: (Dr. James Evans, Chairman Committee) Operative Clinics, by members of the staff. Dry Clinics. Undulant Fever, Guy Wakefield, M. D.; Diabetes in Children, S. M. Welsh, M. D.; Primary Angiosarcoma of Liver, E. E. Gallagher, M. D.; Osteomyelitis, R. E. Flynn, M. D.; Thyroglossal Cyst, E. H. Townsend, M. D.; Gastric Defects seen in X-ray, J. McLoone, M. D.; Clinical Pathological Conference, J. Evans, M. D. and J. Miles, M. D.; Cautery Punch of Prostate, W. E. Bannen, M. D.; (1) Hypernephroma with Bone Metastasis, (2) Bone Grafting, H. Wolf, M. D.

Afternoon and Evening Program at Hotel Stoddard: Syphilitic Aortitis, Wm. Middleton, M. D., Madison, professor of medicine, University of Wisconsin; The Interpretation and Management of Pain in Infancy, J. E. Gonce, M. D., Madison, professor of pediatrics, University of Wisconsin; Epidermophytosis (Its Local and Systemic Manifestations), Paul A. O'Leary, M. D., Rochester, Minnesota, chief of the dermatological section, Mayo Clinic; Acute Lesions in the Upper Abdomen—Frederick A. Stratton, M. D., Milwaukee, professor of surgery, Marquette University. Intermission. Moving pictures of obstetrical and surgical subjects were shown, courtesy of E. Lilly and Company. Banquet and entertainment. The Care of the Disabled War Veteran, Otho A. Fiedler, M. D., Sheboygan, President of the State Medical Society of Wisconsin; X-ray Interpretation of Gastrointestinal Lesions—Frank W. Mackoy, M. D., Milwaukee, chief radiologist, Sacred Heart Sanitarium.

A business meeting concluded the program at which time the following officers were elected for the ensuing year: Dr. E. H. Townsend, La Crosse, President; Dr. R. L. Eagan, La Crosse, Secretary. The 1933 meeting will again be held in La Crosse. One hundred physicians attended the meeting.

NINTH COUNCILOR DISTRICT

The spring meeting of the Ninth Councilor District Medical Society was held at Stevens Point on the afternoon and evening of April 27th.

A medical clinic was held at four o'clock in the staff room of St. Michael's Hospital by Dr. Charles A. Elliott, professor of medicine, Northwestern University Medical School, Chicago.

Following the six-thirty o'clock dinner at the Hotel Whiting, the business meeting and election of officers took place. Dr. W. H. Bayer of Merrill was elected president for 1933, and Dr. Joseph F. Smith of Wausau was re-elected secretary. Dr. Bayer succeeds Dr. W. G. Sexton of Marshfield.

The following papers were then given:

"The Treatment of Circulatory Failure in Acute Infectious Diseases," by Dr. Charles A. Elliott, Chicago.

"The Commoner Forms of Insanity and Their Treatment" by Dr. James C. Hassall, medical superintendent, Oconomowoc Health Resort, Oconomowoc.

UNIVERSITY OF WISCONSIN

Dr. Ernst Waldschmidt–Leitz, professor of biochemistry, Deutsche Technische Hochschule, Prague, Czechoslovakia, gave two lectures on Friday, May 6th. "Specificity and Mode of Action of Proteolytic Enzymes" was the subject of his address in the afternoon in the biology auditorium and in the evening he lectured on "Mode of Action of Specific Enzymatical Activators" at the Service Memorial Institutes building. Both lectures were open to the public.

THE WOMAN'S AUXILIARY

Mrs. Orvil O'Neal, Ripon, Editor

GREEN LAKE–WAUSHARA–ADAMS

The Green Lake–Waushara–Adams County Auxiliary met with the Doctors at Hotel Chase, Wautoma, for a six-thirty dinner Tuesday, April twenty-sixth. We found that the meeting was so planned that the Lions club was meeting jointly with us for the dinner. They furnished very agreeable entertainment with their songs, quartets, both vocal and instrumental, from the High School pupils. The members of the Lions club remained for the meeting with the doctors to hear State President Dr. Otho Fiedler give an address of equal interest to the laity as well as the doctors. The address was one of great value in driving home to those present the great value of having a frequent physical examination as Dr. Fiedler drew illustrations from his large and extensive practice that could not fail to impress upon the audience that he was talking from the heart as well as from wide experience in handling physical check-ups and showing the value of the same. If many more of our citizens could have the chance to listen to such wonderful talks I am sure much could be accomplished in early diagnosis which is so essential in uncovering condition which, if taken early would prolong life and make for much happiness in keeping those in their most useful years for many more years of useful activity.

The auxiliary held their meeting at the home of Dr. and Mrs. A. A. Beck where the doctors joined us for a social hour. Dr. and Mrs. Treadwell of Rock County were guests.

ROCK COUNTY AUXILIARY

At the March meeting Mr. Crownhart gave an interesting talk on State Medicine. There were eighteen members present. We were honored in having with us Mrs. Crownhart and Miss Margaret Johnston, superintendent of the Beloit Municipal Hospital who was the dinner guest of Dr. Jessie P. Allen.

May third, Dr. Jessie P. Allen, Beloit, founder of the auxiliary of the Rock county medical society, gave a talk on "Vivisection" at a meeting of the Auxiliary at the hotel Hilton.

The president of the auxiliary, Mrs. T. O. Nuzum, announced that an open meeting is being planned for May 31 in Janesville. An address will be given by Dr. W. W. Bauer, director of the bureau of health and public instruction of the American Medical Association and assistant editor of Hygeia.

Dr. Francis McMahon, Milwaukee surgeon and member of the Marquette University faculty, gave an illustrated lecture on "Diseases of the Breast". at the medical society meeting.

Mrs. Harry Kasten, Beloit, chairman of the philanthropic committee of the auxiliary, reported that Beloit federated clubs are giving seeds and plants to Pinehurst sanatorium. The following organizations will give entertainments during the year: Fine Arts club, MacDowell club, and the Janesville High School band.

NEWS ITEMS AND PERSONALS

Dr. L. E. Dockry, Kewaunee, was chosen president of the Kewaunee Rotary Club for the ensuing year at a May meeting of the organization held at Hotel Karsten, Kewaunee.

"The Value of Milk in the Diet" was discussed by Dr. E. C. Hartman of Janesville over station WCLO. The talk was presented under the auspices of the Janesville Pure Milk Foundation.

Dr. W. A. Henke, chairman of the La Crosse Board of Health, has been reappointed for a three-year term.

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Dr. and Mrs. Hugh H. Williams of Sparta spent the months of January and February in Florida.

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Dr. Ralph B. Quinn of Darlington was appointed health officer at a recent meeting of the city council.

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Dr. H. P. Greeley, Madison, was elected chief-of-staff of Madison General Hospital at an April meeting. Others elected were: Dr. R. T. Cooksey, vice-president; Dr. R. M. Wheeler, secretary; Dr. E. M. Juster, treasurer, and Dr. L. V. Littig, Dr. L. McGary, and Dr. A. R. Tormey were elected to the executive committee.

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An address on "Child Health" was delivered on May 9th by Dr. L. O. Helmes of Oshkosh before a regular meeting of the American Legion auxiliary at the Moose Hall.

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The Dean Clinic, Madison, announces the association of Dr. Charles F. Burke, whose practice will be limited to diagnosis and internal medicine. Since October, 1928, Dr. Burke had been serving as a fellow in internal medicine with the Mayo Clinic.

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Plans are now under way to establish a hospital at Clintonville. The former home of Dr. E. A. Miller has been leased for this purpose and it is proposed to equip a modern operating room and furnish the necessary rooms. Two registered nurses will be in charge of the hospital. Various organizations of the city are assisting in preparing the institution which will be open soon.

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Dr. August Sauthoff, Mendota, spoke on his recent Mediterranean trip before the Madison Turnverein Club on May 16th.

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Dr. J. W. Prentice of Ashland was renamed county physician at a recent meeting of the County Board.

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Dr. F. J. Hodges and family of Ann Arbor, Mich., formerly connected with the University of Wisconsin, visited friends in Madison during May.

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Dr. F. F. Bowman, health commissioner for Madison, was the principal speaker at the annual dinner of the Fond du Lac Public Welfare Association on May 10th. His subject was "How to Preserve the Health in These Times."

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Members from out of the city who visited the offices of the State Society during May included Doctors A. E. Genter and J. P. Zohlen of Sheboygan; Mead Burke of Kendall and A. H. Heidner of West Bend.

Dr. V. A. Gudex of the State Board of Health was speaker at a meeting of the American Legion of Appleton in May. Dr. Gudex spoke on vaccination.

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Dr. George N. Pratt of Appleton was elected a delegate to the state convention of the American Legion to be held in La Crosse in August.

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An address on industrial surgery was given by Dr. R. L. Prees of North Fond du Lac before a meeting of the Fond du Lac Lions Club the latter part of April.

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Johann Fuerst, found guilty of practicing medicine in the village of Kohler without a license, was fined $300 and costs by Circuit Judge Edward Voigt. The alternative was an eight months jail sentence. Judge Voigt denounced Fuerst as a faker and crook. "You are worse than a crook in some respects because you prey upon the sick and unfortunate. With your 'concentrator' you appealed to the superstitious, the Judge said.

Fuerst claimed he did not receive compensation for his services but that he did sell medicine to persons who came to him for treatment. The "concentrator" referred to is a leather belt which Fuerst said he fastened around his head for the purpose of aiding him to determine ailments.

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Dr. H. E. Kasten of Beloit was speaker before the meeting of the Wisconsin Urological Society held in Iowa City on April 23rd. Dr. Kasten spoke on "European Urological Clinics."

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Dr. J. J. Kronzer, health commissioner of Oshkosh, spoke on preventive medicine before a meeting of the Oshkosh Lions Club in May.

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Dr. W. W. Kelly of Green Bay attended a meeting at Madison of the University of Wisconsin Board of Visitors of which he is a member.

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The tenth anniversary of the Sheboygan Clinic, which was founded May 1, 1922, was observed Saturday evening, April 29th at the Clinic building. One hundred and twelve Wisconsin physicians were present.

Dr. M. S. Henderson, president of the Minnesota State Medical Association and chief of the orthopedic section of the Mayo Clinic, was the guest speaker of the evening. His subject was "Diagnosis and Treatment of Various Joint Diseases."

Dr. Otho A. Fiedler, President of the Clinic, was master of ceremonies and gave the address of welcome. An informal talk was given by Dr. Charles M. Gleason of Manitowoc, on behalf of the visiting physicians.

Preceding the program a buffet supper was served at six-thirty o'clock at the Clinic.

A total of 519 patients have received free treatment at the Beloit branch of the Rock County Free Medical Clinic during the first six months of the Clinic's operation, it was announced in May. Nineteen major and 71 minor operations were performed, all without cost to the patients. Eighty-three patients were hospitalized for a total of 477 days.

Patients referred to eye, ear, nose and throat specialists during the six month period numbered 126. The number referred to dentists was 166, to special clinics 99. Laboratory analysis numbered 415 and 123 x-rays were taken.

Physicians who gave their services on general clinic duties during April were Drs. F. A. Thayer, C. F. N. Schram, W. J. Allen, H. A. Raube, T. F. Shinnick, P. A. Fox, F. E. Brinckerhoff, L. J. Friend and H. A. Shearer.

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Dr. F. A. Nause was reelected president and Dr. G. J. Hilebrand, secretary of the Sheboygan Board of Health at its annual meeting in May.

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An achievement upon which "any state should look with pride" was the praise given Wisconsin's record of first award for Milwaukee and honorable mention for Kenosha, Racine and Shorewood in the 1931 national health conservation contest, in a letter received by the State Board of Health from Carl E. Buck, field director of the American Public Health Association.

Competing cities numbered 265, representing 45 states.

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MILWAUKEE

Dr. G. V. I. Brown gave a talk, illustrated by slides showing the accomplishments of plastic surgery, at the meeting of the Milwaukee Rotary Club on May third.

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Dr. Edwin B. Gute, health commissioner of Whitefish Bay, was reappointed to that office for a term of one year at a meeting of the village health board on May second.

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Visitors at the Century of Progress Exposition, to be held in Chicago in 1933, will be given "push button instruction" under the direction of Dr. Eben J. Carey, director of the department of anatomy, Marquette University Medical School, who is in charge of the medical exhibits for the Exposition.

Through ingenious models, visitors to the Exposition will be able to see how the body works. By simply pushing the right button, the blood circulating through the body, the valves of the heart in action, the working of the lungs, the operation of the stomach, and other interesting and instructive features of the human body may be viewed. Another model will be a transparent figure of the body giving a view of all its machinery.

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When the Milwaukee County Old Settlers met on May second, five new members were elected,—among them the Reverend Herman L. Fritschel, superintendent of Milwaukee Hospital.

—△—

Dr. Elisabeth Seiler gave two lectures at the meeting of the National Society for the Scientific Study of Character, held in Detroit, on April 28th. The subjects of Dr. Seiler's addresses were "Left-handedness and How to Read a Biography."

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Dr. M. A. Bussewitz addressed the members of the Professional and Business Women's Club at their meeting held on May 10th.

—△—

Dr. and Mrs. A. J. Patek left Milwaukee on May 6th for a ten days' visit with Dr. and Mrs. A. J. Patek, Jr., of Cleveland, Ohio.

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Dr. J. Gurney Taylor, who underwent an operation at the Milwaukee Hospital for the removal of gall stones the latter part of April, is reported to be making a splendid recovery. Dr. Taylor left the hospital on May tenth.

—△—

Mrs. Mathilda L. Thorstensen, mother of Dr. Arthur H. Thorstensen, died at her home, 2064 S. 29th Street, on April 26th, at the age of sixty-eight years.

—△—

Dr. Walter M. Kearns was elected president of the Wisconsin Urological Society at the annual meeting held, by invitation, at the University of Iowa the latter part of April.

Included in the Milwaukee group who attended this meeting were Drs. W. J. Gray, James C. Sargent, W. J. McKillip, and M. W. Sherwood.

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Dr. and Mrs. William L. Herner returned to Milwaukee on May 7th from an extended stay in Tucson, Arizona.

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Dr. and Mrs. J. Foster McNary returned to Milwaukee the first week in May from a month's trip to Washington, D. C., and Miami, Florida. Upon their return they were visited by their daughter, Miss Henrietta McNary, of Chicago.

—△—

Dr. Karl E. Kassowitz talked on "A War Prisoner in Siberia and My Escape to America" at the Sunday evening meeting of the Deutscher Club on April 24th.

—△—

Zalmon Franklin, sixteen year old son of Dr. and Mrs. Isadore Franklin, died on Wednesday, April 20th, at the Columbia Hospital after a short illness. He had been suffering from a rare blood disease.

Besides his parents he is survived by two sisters, Edith and Lillian. Zalmon was a junior at the Riverside High School.

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Announcement was made on April 21st by Dr. John P. Koehler, health commissioner of Milwaukee, of the appointment of Drs. Bernard Churchill and

S. H. Wolter to the staff of the Johnston Emergency Hospital.

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About two hundred and twenty physicians with their wives and guests attended the first annual dinner dance sponsored by the Medical Society of Milwaukee County and the Woman's Auxiliary. It was unusually successful as it was the first venture of this kind for the Society.

Those in charge of the affair were the social committee of the Society, of which Dr. H. O. Zurheide is Chairman and Drs. C. W. Long, R. H. Frederick, A. H. Lahmann, and W. W. Hume, members, and Mrs. James C. Sargent, president of the Woman's Auxiliary.

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Dr. Frederick Korthals, who recently underwent a goiter operation at the Milwaukee Hospital, is reported on the road to recovery.

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Dr. and Mrs. Elston L. Belknap and children returned to Milwaukee on May 11th from a ten-day trip to southern Indiana. Dr. Belknap attended the convention of the Society for Clinical Investigation and the American Association of Physicians in Atlantic City.

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Announcement has been of the following office removals: Dr. John L. Garvey to Suite 1110–1111 Bankers Building, 208 E. Wisconsin Avenue; Dr. James H. Hackett to his residence, E. Park Place and N. Downer Avenue; Drs. O. H. and H. R. Foerster and Dr. L. M. Wieder to Suite 1122 Bankers Building, 208 E. Wisconsin Avenue.

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Dr. M. A. Bussewitz spoke on "Education And World Problems" at a meeting of the Business and Professional Women's Club of Milwaukee on May tenth.

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Dr. Joseph J. Eisenberg announces the opening of his new clinic, known as the Dr. Joseph J. Eisenberg Clinic, located at 839 N. Eleventh Street, which opened on May first.

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Dr. S. M. Turkeltaub who for some time has been associated with Dr. Walter M. Kearns, will leave for New York City about the middle of June. He has accepted a surgical residency at Mt. Sinai Hospital for one year after which he expects to do some postgraduate work at the Columbia University School of Medicine.

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Dr. Edgar Habeck and Dr. John H. Reynolds have been appointed as representatives of The Medical Society of Milwaukee County to serve on an Advisory Board for the South View Isolation Hospital. These physicians were appointed at the request of Dr. John P. Koehler, Milwaukee Commissioner of Health.

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Dr. and Mrs. Edward Quick returned to Milwaukee in mid-May from a visit in Omaha, Nebraska.

The following physicians attended the meeting of the American Medical Association held in New Orleans May 9–13: Drs. H. J. Gramling, James C. Sargent, G. H. Fellman, H. R. Foerster, G. V. I. Brown, Eben J. Carey, M. G. Peterman, L. D. Smith, C. C. Schneider, Rock Sleyster, F. H. Haessler, and Mr. Theodore Wiprud, executive secretary, The Medical Society of Milwaukee County.

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At a meeting of the Board of Directors, held at the City Club on May 4th, it was recommended that The Medical Society of Milwaukee County provide a non-resident class of membership for members of nearby county medical societies who wish to become members of this Society.

The Board approved President Currer's appointment of Drs. Edgar Habeck and J. H. Reynolds to the Advisory Board of the South View Isolation Hospital.

A letter was read from Dr. John P. Koehler, Commissioner of Health in Milwaukee, in which he expressed appreciation for the part played by the Society in the honors conferred upon Milwaukee on having the best health record of any city of its size in the United States, in the recent National Inter-Chamber Health Conservation Contest.

The Board amended its previous recommendation to Milwaukee hospitals that all regular members of medical staffs be required to be members of The Medical Society of Milwaukee County to read "that all regular members of medical staffs of Milwaukee hospitals be required to be members of a county medical society."

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The outline of the proposed study of free medical services in Milwaukee County, to be made by the Milwaukee Real Estate Board and a special committee appointed by President Currer, was presented to the Board for their consideration. The Board approved the outline as a basis for study.

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The purpose of the meeting of the Child Welfare and Public Nursing Committee, held in the Mariner Tower on May 6th, was to consider with Mr. W. L. Coffey, manager of Milwaukee County Institutions, the diet list of the Department of Outdoor Relief. After a careful consideration of the list submitted the Committee went on record approving it.

BIRTHS

A daughter to Dr. and Mrs. William O'Malley, Milwaukee, March 31st.

A daughter to Dr. and Mrs. H. L. Doeringsfeld, Milwaukee, April 17th.

A son to Dr. and Mrs. P. E. Oberbreckling, Milwaukee, April 27th.

A daughter to Dr. and Mrs. John B. Hitz, Milwaukee, May 11th.

A daughter, Imogene, to Dr. and Mrs. J. P. Zohlen, Sheboygan on May 5th.

A son to Dr. and Mrs. J. E. Gonce, Jr., Madison, on May 17th.

MARRIAGES

Dr. George E. Thill, Milwaukee, to Miss Marion K. Moroney, Milwaukee on May 21st.

Dr. Ralph W. Garens, Milwaukee, to Miss Hazel Schule of Milwaukee.

Dr. L. V. Sprague, Madison, to Miss Virginia Clement of Glen Ellyn, Ill., on May 8th.

Dr. Clarence E. Baumle, Monroe, to Miss Henrietta R. Field of Chicago, on April 30th.

DEATHS

Dr. Sidney Storrs Hall, treasurer emeritus and a former president of the State Medical Society of Wisconsin, died at Minneapolis on May 7th. He had been in ill health for some time but died of pneumonia following an operation performed a week previous to his death.

Dr. Hall was born at East Bloomfield, N. Y., March 1, 1844. When he was seven years old his parents moved to Rosendale, Wisconsin. On July 16, 1864 he entered the service of the U. S. Navy as surgeon's steward on the "Cricket," a gun boat of the Mississippi squadron. He remained in service until the end of the war. Following graduation from Harvard University Medical School in 1867, he joined his father in practice at Rosendale where he remained for two years. He then practiced at Sheboygan for five years; Morrison, Ill., eight years, and forty-two years at Ripon, Wisconsin. He retired shortly after his eightieth birthday to make his home with his daughter, Jennie, in Minneapolis.

From 1891 to 1918, Dr. Hall was treasurer of the State Society and in 1922 served as its president. In January, 1925, he was made an honorary member of the Green Lake–Waushara–Adams County Medical Society and of the State Medical Society.

Surviving are his two daughters, Mrs. James A. Older of Portage and Miss Jennie Hall, Minneapolis, and two sons, Edwin C., Wauwatosa, and Robert S., Cleveland Heights, Ohio. Another son, Dr. John Storrs Hall died at Ripon in 1902. Five grandsons and two granddaughters also survive.

Burial took place at Ripon on May 9th, Dr. Silas Evans, president of Ripon College, assisted by Dr. Smith of Oshkosh conducted the services.

Dr. Louis Schapiro, a former Milwaukee physician, died in Bangkok, Siam, on February fourth, at the age of 46 years.

After graduation from the public schools of Milwaukee, Dr. Schapiro attended the George Washington University Medical College in Washington, D. C., from which he was graduated at the age of twenty years. He then entered Harvard University for the completion of his medical work.

For five years he was government physician in the Philippine Islands, after which he returned to Milwaukee where he engaged in private practice for a few years before accepting a position as research worker in tropical diseases in the Orient.

Besides his widow, he is survived by a son, Mark, his parents, who reside in Milwaukee, a sister, Mrs. A. J. Lewis, of Milwaukee, and two brothers, Dr. Saul Schapiro, Brooklyn, New York, and Alfred, of Pittsburgh, Pennsylvania.

Dr. John M. Ross, Richland Center, died May 7th at the Richland Hospital. Death was due to a meningitis following an otitis media and mastoid infection.

Dr. Ross was born Aug. 25, 1883, in the town of Richland, Richland County, Wisconsin, and attended the public schools and High School at Richland Center. After graduating from the St. Louis College of Physicians and Surgeons he practiced medicine at Sylvan and Plain, Wisconsin, for one year each and then in 1907 went to Bloom City where he practiced fifteen years. In 1921 he moved to Richland Center and continued his practice there.

Dr. Ross was a former president of the Richland County Medical Society and a member of the State Medical Society and the American Medical Association. He served as lieutenant in the U. S. Army during the World War, being Staff Officer at Fort Riley, Kansas.

He was a member of the American Legion, R. A. M. No. 75, and to Richland Commandry No. 48. He was a member of the Milwaukee Consistory and the Tripoli Shrine.

He is survived by his widow.

Dr. Argo M. Foster, Racine, died on May 3rd at his home following a short illness.

Dr. Foster was born in the year 1865 and was a graduate of the Michigan College of Medicine and Surgery, Detroit, in 1892. He practiced for a time in Kaukauna and for the past eighteen years practiced in Racine.

He is survived by his widow.

Dr. Albert P. Minshall, Viroqua, died on May 17th. He had been in ill health for the past few years.

Dr. Minshall was born in the year 1862 and was a graduate of the College of Physicians and Surgeons of Keokuk, Iowa, in 1890. He had practiced in Viroqua for forty years.

SOCIETY RECORDS

New Members

A. J. Williams, 412—6th Street, Racine.

E. L. Watson, Columbus Clinic, Columbus.

George W. Fox, Jr., 2118 E. Kenilworth Place, Milwaukee.

E. A. Titel, Greenleaf.

Frank E. Drew, Jr., 231 W. Wisconsin Ave., Milwaukee.

Erwin C. Van Valin, Sussex.

G. L. Rothenmaier, Elkhart Lake Bank Bldg., Elkhart Lake.

F. S. Tuffley, Boscobel.

Changes in Address

Margaret V. Pirsch, Louisville, Ky., to 6003 Seventh Ave., Kenosha.

Verne W. Carlson, Lake Mills to 2309 Bryant Ave. S., Minneapolis.

» » » CORRESPONDENCE « « «

THE SECRETARY'S SALARY

May 24, 1932.

Mr. J. G. Crownhart,
Madison, Wis.
Dear George:

The old doctors of our local society feel that the state fee is much too high; that it was slipped over on them and that the whole increase is to swell your salary out of proportion with the times, and they are intending to cooperate with other county societies to draft a petition to lower your salary and to lower the State Society expenses and consequently the fee. I don't know what your salary is but I do know you are doing a very big work and that you would not prey upon the profession.

Yours truly,

A MEMBER

THE ANSWER

Dear Doctor_____:

I am appreciative of your advising me of the feeling that the salary of the Secretary has been raised since the dues were increased, and of the further suggestion current in your Society that such increase was the purpose of the present dues.

This note is forwarded at once to advise you that when I suggested the increase in dues to the Council for the purpose of increasing the activities of the Society in behalf of the general membership, I was told that if I undertook to advocate such extension I must not expect to receive any further increases in my salary. I did advocate such extension and I have not had any increase in salary since one year before the increased dues became effective.

Cordially and sincerely yours,

J. G. CROWNHART,
Secretary,

"INDUSTRIAL NURSES GRATEFUL"

EMPLOYERS MUTUAL LIABILITY INSURANCE CO.
OF WISCONSIN

Wausau, Wis., April 19, 1932.

J. G. Crownhart, Secretary,
The State Medical Society of Wisconsin,
Madison, Wisconsin.
My dear Mr. Crownhart:

The industrial nurses of Wisconsin will be grateful for the pamphlet on Standing Orders. I feel sure the suggestions contained therein will be followed and that the nurse will enlist the aid of the physician in charge to modify or add to these orders as suggested.

May I ask whether or not a letter such as you wrote me has been written to all industrial nurses in the State of Wisconsin?

In my contact with registered nurses employed by our policyholders I shall be glad to work with the State Medical Society to see that the suggestions are followed as I have in the past, and also encourage closer contact between the industrial nurses and the physicians interested in the plants and the family physician of the employe.

Sincerely yours,

EMPLOYERS MUTUAL LIABILITY INSURANCE CO.,
By Joanna M. Johnson, R. N.,
Industrial First Aid Dept.

JMJohnson HE

"GREAT SERVICE"

CITY OF FORT ATKINSON
Wisconsin

Municipal Building, May 25, 1932.

Mr. George Crownhart, Sec'y.,
State Medical Society of Wis.,
119 E. Washington Ave.,
Madison, Wis.
Dear Sir:

If consistent will you please send me two copies of pamphlet "Summary of Wisconsin Poor Relief Laws Affecting Care of Indigent Sick". A copy of this booklet which I recently had an opportunity of examining would be of great service, convenience and saving in time over having to look up matters regarding which need advice or instruction in the State Statutes. The second copy I wish to furnish to our City and School Nurse whose duties make it necessary for her to be conversant with the law pertaining to cases in which she is interested.

Yours truly,

W. B. CARPENTER,
Employment Director.

WBC:MB

REPORTS IN JULY ISSUE

Reports of the officers and committees of the State Society will be published in the July issue of the Journal. These reports will outline the accomplishments of the Society during the past year and will be of interest to every member.

Program for Ninety-First Annual Session at Milwaukee, September 14-16, Nears Completion: Guest Speakers Headed by Crile and Barr

Arrangements for the Scientific Program for the annual meeting are practically completed according to Dr. T. L. Squier, Milwaukee, Chairman of the Committee on Scientific Work. Wednesday morning from 8:00 to 10:00 clinics and demonstrations will be held in the various Milwaukee hospitals. Admission to all hospital clinics will be by ticket and registration for these clinics will be made in advance of the meeting. At 10:30 the general session will begin.

As in previous years, round table luncheons will be held on Thursday noon. Dr. George Crile will deliver the oration in surgery and Dr. David Barr the oration in medicine. Other guest speakers include Dr. Max Cutter of Chicago, who will speak on Clinical and Pathological Aspects of the Cancer Problem; Dr. Samuel Amberg, Rochester, Minn.: Observations on Abdominal Conditions in Childhood; Dr. W. W. Duke, Kansas City; Allergy; Dr. Charles H. Watkins, Rochester, Minn.: Leukopenia and Acute Leukemias with the Differential Diagnosis from Similar Blood Conditions; Dr. Ellsworth S. Smith, St. Louis: The Treatment of Heart Disease; Dr. E. T. Bell, Minneapolis: Nephritis; and Dr. Julius Bauer of Vienna, Austria.

The program provides papers covering a wide variety of interests and it is felt that all will find much of practical value.

Detailed announcements will follow in the July issue.

American Medical Association to Meet in Milwaukee in 1933; Dr. Rock Sleyster Re-elected Trustee at New Orleans Meeting

Accepting the invitations of the Medical Society of Milwaukee County and the State Medical Society of Wisconsin, the House of Delegates of the American Medical Association selected Milwaukee as the place of the 1933 meeting. This is the first meeting of the A.M.A. in Milwaukee in fifty years and Wisconsin won over Cleveland and Atlantic City by a vote of 73 to 41 and 11. The meeting will probably be held the first part of June.

At the same meeting of the House, Dr. Rock Sleyster, Wauwatosa, Treasurer of the State Society, was re-elected to a five-year term on the Board of Trustees. Dr. Dean Lewis, Baltimore, was made President-elect of the Association with Dr. Rudolph Matas, New Orleans, Vice-president.

Wisconsin delegates, Drs. Joseph F. Smith, Wausau; W. E. Bannen, La Crosse, and F. Gregory Connell, Oshkosh, (serving for J. Gurney Taylor, ill) were in attendance at all sessions of the House covering the four-day period. Dr. Smith was named a member of the important reference committee on Reports of Officers and Dr. Connell presented the invitation to the House to hold the '33 meeting in Milwaukee. Proceedings of the House are published in full in the Journal of the A.M.A.

Among the Wisconsin registrants at the New Orleans meeting were:

Bannen, W. E.	La Crosse
Brumbaugh, E. V.	Milwaukee
Carey, Eben J.	Milwaukee
Connell, F. Gregory	Oshkosh
Crosley, G. E.	Milton
Crownhart, Mr. J. G.	Madison
Ewell, G. H.	Madison
Fellman, G. H.	Milwaukee
Foerster, H. R.	Milwaukee
Foerster, O. H.	Milwaukee
Gaenslen, F. J.	Milwaukee
Ganser, Wm. J.	Madison
Gramling, E. H.	Milwaukee
Gramling, H. J.	Milwaukee
Gramling, J. J.	Milwaukee
Grinde, G. A.	Cumberland
Haessler, F. H.	Milwaukee
Mantell, F. J.	Racine
McKillip, W. J.	Milwaukee
Peterman, M. G.	Milwaukee
Rhea, C. W.	Waukesha
Sargent, J. C.	Milwaukee
Schneider, C. C.	Milwaukee
Schuster, B. L.	Chippewa Falls
Sevringhaus, E. L.	Madison
Sleyster, Rock	Wauwatosa
Smith, Joseph F.	Wausau
Stemper, Irene T.	Oconomowoc
Stuessy, Milton F.	Blanchardville
Wiprud, Mr. Theodore	Milwaukee

Pediatrics Is Summer Postgraduate Program For Southeastern Wisconsin Physician

Dr. Wayne A. Rupe

An attractive opportunity for taking a postgraduate course in Pediatrics near at home will be offered by the Society this summer to physicians in the southeastern counties. A six weeks' course will be conducted at five centers under the leadership of Dr. Wayne A. Rupe of Washington University, St. Louis, Missouri.

This is another in the series of postgraduate courses which have been sponsored by the Society in cooperation with the University of Wisconsin Medical School and the University Extension Division.

The meetings will begin during the week of July 11 in the following cities:

Milwaukee (2 classes)	Racine
	Kenosha
Waukesha	Burlington

SCHEDULE TO SUIT ALL

The meetings in each center will be held on the same day each week and at the same hour and place. The arrangements for each group will be determined with reference to the desires of the greatest number of physicians registering. All registrants will be informed well in advance concerning these local arrangements.

Dr. Rupe comes to Wisconsin this year with the prestige of a former highly successful experience in this state with a postgraduate course in the same subject. In 1928 he taught Pediatrics in an extension course at Madison, Watertown, Janesville, Fond du Lac, Beloit, Beaver Dam, New London, Marshfield, Stevens Point, Wausau, Antigo, and Rhinelander. One physician in this course, writing his impressions of its value, said, "If men of the caliber of Dr. Rupe are used, I see no way to improve these extension courses."

THE CLASS TOPICS

The class topics for this course follow:

1. Discussion relative to newer methods of prevention and treatment of certain contagious diseases, whooping cough, measles, scarlet fever, diphtheria, erysipelas, poliomyelitis. Also prevention of serum sickness and anaphylactic reaction.
2. Discussion of newer ideas about the breast feeding and the artificial feeding of the normal infant through the first year of life. More effective types of artificial feeding and indication for use. The control of vomiting, constipation, etc.
3. Causes and treatment of the various types of infantile colic, including the so-called nervous colic. Diagnosis and treatment of pylorospasm, pyloric stenosis.
4. Causes, prevention, and treatment of diarrhea in infancy. Treatment of the premature and immature baby. Treatment of the marasmic.
5. Treatment of infantile skin diseases, eczema, the diaper rash, etc. Treatment of asthma. General discussion of the tonsil and adenoid problem.
6. Treatment of pyelitis, enuresis, nephritis, and nephrosis. In discussing clinical cases the handling of many physical diseases as well as the handling of psychic disturbances and behavior problems will be taken up. The following disturbances will be touched upon: breath holding, nervousness, intestinal parasites, anorexia in older children, the under-weight child, thumb-sucking, convulsions, etc.

Dr. Rupe is a graduate of the University of Missouri and took his M. D. degree at Washington University in 1918. His experience has been as follows: Interne, assistant resident physician, and resident physician, St. Louis Children's Hospital, 1918–1922; instructor in pediatrics, University of Minnesota, 1923–1924; acting chief of outpatient department, Washington University, 1924–1926; in private practice and instructor in clinical pediatrics, Washington University, 1924 to present time.

Dr. Rupe is a member of the St. Louis Pediatrics Society, the St. Louis and Missouri State Medical Societies, and the American Medical Association. He has made

many contributions to medical publications, and conducted postgraduate courses in North Carolina, Oklahoma, Kansas, and Wisconsin.

ENROLLMENT INFORMATION

The fee for the six weeks' course is $15 Application may be made to the University Extension Division, 623 West State Street (Room 109), Milwaukee.

The medical extension advisory committee for this course includes the following:

For the State Medical Society: **Dr. Otho A. Fiedler, Sheboygan; Dr. G. Gundersen, La Crosse; Dr. J F. Wilkinson, Oconomowoc; Dr. M. D. Bird, Marinette; Dr. K. H. Doege, Jr., Marshfield; Dr. A. J. Wiesender, Berlin; J. G. Crownhart, Madison.**

For the University of Wisconsin Medical School: **Dean C. R. Bardeen, Dr. R. C. Buerki, Dr. J. S. Evans, Dr. J. E. Gonce.**

For the University Extension Division: **Dean Chester D. Snell, Malcolm G. Little, Chester Allen, Nelson D. Conners.**

DECLARE LECTURES EXCELLENT

Dr. Rupe has presented this course in other parts of the state. A year ago seventy-nine of eighty-one in attendance at his course declared that the lectures were excellent or very good. The following comments are taken which were direct to the Extension Division following his Course:

"I want to say that you gave us a splendid lecturer,—in fact the best that I have heard in pediatrics," declared Dr. J. B. Vedder of Marshfield. "He was a very practical talker and easy to listen to. If you keep up with this class of men this extension work will surely be a success."

"You selected an excellent specialist and I feel that my time and money were very well spent," wrote Dr. B. H. Dike of Owen.

"Continue the courses and secure as efficient an instructor as was Dr. Rupe to carry on in years to come," said Dr. J. F. Clark of Laona.

"The course of lectures on pediatrics given by Dr. Wayne Rupe is the finest and most complete summary of scientific accomplishment in diagnosis and treatment that it is possible to obtain in a short time," declared Dr. J. F. Wilkinson of Oconomowoc. "He wastes no time on experimental or theoretical types of treatment and gives only facts of proven value with regard to the practical methods of raising normal, healthy children and protecting them from disease."

Michigan Announces Plans for Extensive Survey in Field of Medical Economics

The plan of work for the study of medical economics and the costs of illness in the state of Michigan were announced by the special committee of the Michigan State Medical Society in May. Dr. Nathan Sinai, who has been associated in making similar studies for the College of Dental Surgeons and the National Committee on the Cost of Medical Care has been selected as the director of the study in Michigan. It is understood that the complete study will cost in excess of $25,000.

The outline for the study plan in Michigan is printed herewith and will be of particular interest to Wisconsin physicians in view of the somewhat similar study being made presently, report of which is to be made at the September meeting of the House of Delegates.

STUDY PLAN

I. Appointment of Committees on Public Relations by County Societies.
II. Appointment of special sub-committees by State Committee.
  A. University Hospital Committee.
  B. State Hospital Committees.
    1. Tuberculosis.
    2. Mental.
  C. Other.
    1. Laboratory committee.
    2. Public health committee.
    3. Industrial committee.
III. Preparation and approval of "Purpose of Study". (Specimen 1)
IV. Preparation and approval of preliminary survey schedule. (Specimen 2)
V. Preparation and approval of detailed individual schedules.
  A. Physicians. (Specimen 3)
  B. Hospitals (exclusive of mental and tuberculosis) (Specimen 4)
  C. Laboratories (exclusive of hospital laboratories) (Specimen 5)
VI. Preparation and approval of plans for special studies.
  A. Economic structure of population.
  B. Health Agencies. (Specimen 6)
    1. Official.
    2. Nonofficial.
      a. Michigan Children's Fund.
      b. Kellogg fund.
      c. Tuberculosis.
      d. Other.
  C. Industrial Service. (Specimen 7a)
    1. Lodges, etc. (Specimen 7b)
  D. Welfare Service.
  E. Tuberculosis. (Specimen 8)
  F. Mental Diseases. (Specimen 9)
  G. Miscellaneous.
    1. Workmen's Compensation.
    2. Contract Practice.
    3. Experiments in provisions of service.
    4. Medical Society activities.
      a. Scientific.
      b. Public Relations.
    5. Study of patients discharged from hospitals.
      a. Financial and Social data.

VII. Collection of Data.
- A. Preliminary survey (Specimen 2) to be completed by local county society committees.
- B. Detailed individual schedules.
  - 1. Physicians' schedules. (Specimen 3)
    - a. Mailing of preliminary letter (Specimen 10) signed by local committee in each county to all physicians in private practice. (Enclose Specimen 1)
    - b. Mailing of survey schedule, letter (Specimen 11) and return postal card. (Specimen 12)
    - c. Follow-up by local committee.
      - 1. Telephone or personal contact.
  - 2. Hospital schedules. (Specimen 4 or abbreviated schedule)
    - a. Mailing of schedules to local committees.
  - 3. Laboratory schedules. (Specimen 5)
    - a. Mailing of preliminary letter (Specimen 13) signed by local committee.
    - b. Mailing of schedule and return postal card. (Specimen 14)
    - c. Follow-up by local committee.
      - 1. Telephone or personal.
- C. Special Studies.
  - 1. Economic structure of population.
    - a. Distribution by counties.
      - 1. Urban.
      - 2. Rural.
    - b. Economic Data.
      - 1. Distribution of wealth.
      - 2. Incomes.
      - 3. Costs of living.
      - 4. Other county data.
  - 2. Health agencies.
    - a. Data from study for Governor's commission. (Specimen 6)
  - 3. Industrial service.
    - a. Detailed schedule distributed through Manufacturers' Ass'n.
    - b. Schedule to other organizations such as fraternal, etc. (Specimen to be prepared)
  - 4. Welfare Service.
    - a. Data from study for Governor's commission.
      - 1. Afflicted adults.
      - 2. Afflicted children.
      - 3. Crippled children.
      - 4. Mothers' pensions.
  - 5. Tuberculosis.
    - a. Hospital service.
      - 1. Detailed schedule (Specimen 8 to be prepared) to hospitals.
    - b. Clinical service.
      - 1. Data from public health survey.
    - c. Field service.
      - 1. Data from public health survey.
  - 6. Mental Diseases.
    - a. Hospital service.
      - 1. Detailed schedules (Specimen 9 to be prepared) to public and private hospitals.
    - b. Clinical service.
      - 1. Special local studies.
  - 7. Miscellaneous.
    - a. Workmen's Compensation.
      - 1. Analysis of laws.
      - 2. Relation of physician to carriers.
      - 3. Defects and merits.
    - b. Contract practice.
      - 1. Data from physician's schedules.
      - 2. Data from industrial study.
    - c. Experiments.
      - 1. Medical society care of indigents.
      - 2. Group practice.
      - 3. Diagnostic clinics.
      - 4. Immunization by private practitioners.
      - 5. Collection and loan services.
      - 6. Other.
    - d. Medical society activities.
      - 1. Data from local committees concerning scientific programs and public relations activities.
    - e. Patients discharged from hospitals.
      - 1. Costs.
      - 2. How costs were met.

VIII. Analysis and Correlation of Data, by Counties in Michigan.
- A. Physicians.
  - 1. Distribution.
    - a. Urban.
      - 1. Ratio to population.
      - 2. Per capita wealth.
    - b. Rural.
      - 1. Ratio to population.
        - a. Population per square miles.
      - 2. According to land valuation.
        - a. Per cent of land in farms.
  - 2. Ages and years in practice.
    - a. Urban.
    - b. Rural.
      - 1. Correlate with above rural data.
  - 3. Professional training.
    - a. Urban.
    - b. Rural.
  - 4. Post-graduate training.
    - a. Urban.
    - b. Rural.
  - 5. Specialization.
    - a. Urban.
      - 1. Types.
      - 2. Degree.
      - 3. Preparation.
    - b. Rural.
      - 1. As above.
  - 6. Types of cases excluded from practice by general practitioner and partial specialist.
    - a. Urban and rural.
  - 7. Equipment (to be determined by committees).
    - a. Urban and rural.
  - 8. The physician's "normal" week.
    - a. Office practice.
      - 1. Night office calls.
    - b. Home calls.
      - 1. Night calls.
    - c. Hospital calls.
  - 9. Number of patients.
    - a. Urban and rural.
  - 10. Dispensing of drugs.
    - a. Urban and rural.
  - 11. Practice of preventive medicine.
    - a. Urban and rural.
  - 12. Fees.
    - a. Urban and rural.
  - 13. Financial adjustments for patients.
    - a. Method.
    - b. Fee and part-pay service.
  - 14. Hospital affiliations.
    - a. Urban and rural.
  - 15. Gross cash incomes.
    - a. Years 1928-1929-1930-1931.
    - b. Urban incomes.
      - 1. General practitioners.
        - a. Years in practice.
      - 2. Specialists. (partial and complete)
        - a. Years in practice.
        - b. Type of specialty.
    - c. Rural incomes.
      - 1. General practitioners.
        - a. Years in practice.
        - b. Type of community.
          - 1. Correlate with county data.
      - 2. Specialists.
        - a. Years in practice.
        - b. Preparation.
        - c. Type of community.
          - 1. Correlate with county data.
    - d. Income from salary.
      - 1. Public health.
      - 2. Industry.
      - 3. Fraternal.
      - 4. Hospital.
      - 5. Insurance.
      - 6. Teaching.
      - 7. Research.
    - e. Income from contract.
  - 16. Expense.
    - a. Items.
      - 1. Urban and rural.
  - 17. Net incomes (1928-29-30-31).
    - a. Urban and rural.
    - b. Same correlations as "Gross Income".
  - 18. Total book accounts.
    - a. 1928-29-30-31.
  - 19. Normal percentage of collection.
- B. Hospitals (Urban and Rural, other than State Hospitals). Note: Data from state hospitals will be analyzed and correlated with special studies, such as tuberculosis and mental diseases.
  - 1. Distribution and ownership.
    - a. Accredited.
  - 2. Growth of facilities.
    - a. Ten-year period.
    - b. Correlate with population data.
  - 3. Type.
    - a. General.
    - b. Special.
  - 4. Bed capacities.
    - a. By type.
  - 5. Occupancy.
    - a. By class of patient.
      - 1. Economic.
      - 2. Illness.
  - 6. Services.
  - 7. Staff.
    - a. Type.
    - b. Personnel.
    - c. Duties.
  - 8. Record keeping.
    - a. Cases, autopsies.
  - 9. Nurses' training.
  - 10. Financial.
    - a. Gross income. (1928-29-30-31)
      - 1. Sources.
    - b. Expenses.
      - 1. Items.
    - c. Net income. (1928-29-30-31)
      - 1. Method of balancing deficit.
- C. Laboratories. (Urban and Rural, other than hospital and health dept.)
  - 1. Distribution.

2. Ownership.
   a. Personnel.
      1. Training.
3. Type.
   a. Services provided.
4. Gross income. (1928-29-30-31)
   a. By Services.
5. Expense.
   a. Items.
6. Net income. (1928-29-30-31)

D. Analyses and correlation of data from special studies.

IX. Interpretations and Conclusions.
   A. Submit data to sub-committees.
      1. Recommendations of sub-committees.

X. Preparation of final reports.

Medical Witnesses and Expert Testimony

Questions involving the physician as a witness and as an expert arise so frequently that we have requested our legal counsel to prepare this summarized statement for the information of our readers.—Editor's Note.

The changing industrial and social relations of the present day tend to narrow the scope of practice of the medical practitioner to such an extent that he becomes a specialist within his own profession. At the same time his work is becoming of greater importance in the daily affairs of his patients. Thus the medical practitioner is frequently called upon to give testimony in court, either as the attendant physician, as an expert, or as both. The time and demands required in such work have consequently become greater, and thus this phase of practice has become increasingly important.

Physicians are ordinarily quite willing to accommodate their patients and testify concerning such facts and circumstances as are within their knowledge, but either because of lack of experience or inadequate compensation, are unwilling to be in constant attendance upon the trial of a case in order to give expert testimony. The subject herein discussed may be treated more specifically under the following headings: (1) To what extent is a physician compelled to testify; and (2) How may he avoid giving testimony.

1. It is generally understood that a person of skill and reputation in medical or other science is not thereby exempt from the usual duties of citizenship. If he has personal knowledge of certain facts which are in controversy he may be subpoenaed and compelled to testify. Thus where a medical practitioner is called professionally to treat a certain patient, he necessarily forms an opinion as to the nature of the disease or injury, its probable cause and future course, and when thereafter he is called as a witness he may be compelled to testify, not only as to the physical facts which he observed, but as to the opinions which he then formed. For this type of testimony he can claim only the witness fees fixed by law. But he cannot be required to make an examination or preliminary preparation, nor can he be compelled to attend the trial, and listen to the testimony, that he may be better enabled to give his opinion as an expert. For services of the latter character he may with propriety contract for extra compensation. See: 11 R. C. L. 647, et seq., and cases there cited.

This subject has received the attention of the Supreme Court of Wisconsin in the case of *Philler v. Waukesha County,* 139 Wis. 211, where we find an excellent opinion from which we quote in extenso:

> "(Plaintiffs) contend that when a physician is called upon to give expert testimony his services are of a different character and cannot be demanded without compensation. The word 'expert' in this connection is somewhat loose and uncertain. Much of the testimony of a so-called expert is in no wise different in character from that of any other witness. He may be called on to testify to that which he sees, hears, or otherwise discovers by the use of his senses; but those facts may be such that no one but a trained expert would discover them by such use of his senses. A skilled physician discovers facts by the use of sight, hearing, or feeling which another man might not. But this distinction is one of degree merely and not of kind. All men differ in their ability to observe accurately and in the certainty of knowledge which they derive from such observation. An illustration of such testimony, not in the legal sense expert, and yet dependent on the peculiar knowledge and abilities of the witness, is presented in *Hocking v. Windser Spring Co.*, 131 Wis. 532, 111 N. W. 685, where an oculist, not competent under our law to testify as an expert, was allowed to testify to physical injuries which doubtless could not have been seen and discovered or described by a nonprofessional. There can be no doubt in this field

that every man owes a duty to attend and testify to the material facts that he knows notwithstanding the knowledge thereof may be due either to his learning or his expert faculties. Any attempt to draw a line between the exceptionally stupid and nonobservant person and others who, by greater alertness, training or skill in observation, may acquire more knowledge, is impractical and irrational. The educated and intelligent owe the same duty of aid to the courts up to the limit of their ability as does the less competent man—the man whose services are worth $50 per day as well as he whose time is worth but $2. The more difficult field is entered upon when we approach the question of calling upon men of exceptional experience and qualifications to give their opinion as the result either of facts which they observe or from a hypothetical statement of facts. This is the real field of expert evidence. It is there that the expert can testify and the nonexpert cannot.

* * *

"It would seem on principle . . . that if from the witness's observation or from the hypothetical facts stated to him he has consciously in mind either knowledge or an opinion, such knowledge or existent opinion is a fact as to which he may be required to testify; but, as is often the case, and in the higher branches of expert learning perhaps usually, an amount of study, experimentation, thought, and reflection may be necessary to the formation of an opinion, and the witness may often honestly answer that he has not formed such opinion. The chemist, after submitting a substance to various analyses and reactions, may yet need to study the books or make further experimentation before he can assert the presence or absence of certain elements. The physician, after exhaustive inspection and tests, is still often left in doubt, and does not venture an opinion to his patient until after long study. Such study, reflection, etc., is not the function of the ordinary witness. It is not within the command of the subpoena, and there is no reason to think that the statutes were intended to require it of any witness merely as such. If a party desires that any witness, expert or otherwise, equip himself with knowledge by research or inspection, it may employ him to do so, but such employment will be controlled by the ordinary rules of contract, express or implied.

* * *

" . . . the expert, be he mechanic, physician, engineer or chemist, must obey the subpoena of the court and must testify to such facts as are within his knowledge, whether these facts may have required professional learning, study, or skill to ascertain them or not. If, when placed on the witness stand, he has such knowledge, he must testify to it. . . . The subpoena under statutes like ours does not compel the expert nor other witness to equip himself by labor with ability to testify either to an opinion or to any other fact which might be ascertained by special services, and hence that from the mere subpoena and compulsion to testify as a witness results no implied contract upon any one to pay the expert anything in excess of the statutory fees, recognizing, however, that, if he does perform work in preparation and qualification to enable him to testify at the request of any person, implied contract for reasonable compensation may arise, or an express contract will be valid. *Barrus v. Phaneuf*, 166 Mass. 123; *Tiffany v. Kellogg Iron Works*, 109 N. Y. Supp. 754; *Anderson v. M., St. P. & S. S. M. R. Co.*, 103 Minn. 184, 114 N. W. 744; *Schofield v. Little*, 2 Ga. App. 286, 58 S. E. 666".

As suggested earlier, a medical practitioner is often confronted with situations where his knowledge and experience have not fitted him to give expert testimony and he is reluctant to place himself in a position where his professional reputation may be damaged. In such a case he may inform his patient's attorney that, although he has treated the patient and is naturally willing to testify to his findings and the result of his treatment, he does not wish to give expert testimony. If the attorney is insistent upon trying to elicit from him opinion evidence of such a nature, it would seem to be perfectly proper for him to refuse to give an opinion, and if the attorney should appeal to the court, the medical practitioner may state his qualifications and his reasons for not wishing to give such testimony, which may be based upon his lack of experience with the type of injury or disease in question, or upon his lack of opportunity for study of the case with a view to being able to give expert testimony. Ordinarily the court will uphold the practitioner, but if it does not, he may then give his opinion for what it is worth. Thus he protects himself, and ultimately, his pa-

(Continued on page 418)

PRESS SERVICE OF STATE MEDICAL SOCIETY

No serum does so much for public health as printer's ink

RELIEF FROM CANCER

Madison, Wis., May 5.—Notwithstanding much public opinion to the contrary, cancer does not necessarily mean a fatal end.

The relief from cancer in general depends either upon its removal from the body or its destruction in the body. Surgery accomplishes the former; irradiation by x-rays and radium produces the latter.

This is a summarization of an official statement issued today by the Educational Committee of the State Medical Society. It is in response to many inquiries by cancer sufferers who asked for honest information. The statement declares there is no need of despair, if the cases are treated in the early stages.

"The surgical treatment of cancer has established a brilliant record of achievement. It has yielded innumerable successes and has saved many lives," continued the Medical Society's report.

"When a cancer is within easy reach and is quite localized, its direct removal by surgery is a very effective method. When a cancer is deep-seated, or is widely spread throughout the body, its removal is not a simple procedure and the effectiveness of surgery is accordingly limited.

"The employment of radium and x-rays in the treatment of cancer marks a new era in the practice of medicine. Here for the first time an invisible agent, operating at a distance, has been used to accomplish the actual destruction of abnormal growths in the body.

"The successful results of radiation treatment for cancer depend upon the ability of the rays to destroy cancer cells without injuring the surrounding tissues of the body.

"Many cancers, of both the superficial and internal varieties, are destroyed by the application of radium and x-rays.

"The resistance of certain cancers to the destructive influence of radiation limits to some extent, however, the effectiveness of this agency.

"In some cases the combined use of surgery and radium or x-rays, or the employment of all three, is necessary to obtain results.

"In every case of cancer, the early application of correct treatment is absolutely essential for relief. Time is the ruling factor and generally renders the decision on the outcome of the disease. Do not waste time in securing treatment. Money spent on questionable methods can be replaced. The time lost cannot be regained and time is the very essence of all that is known in the relief from cancer."

* * *

CROOKED TEETH

Madison, Wis., May 12.—Crooked teeth are one of the causes of ill health. Not because the teeth are crooked but because their irregularity makes the mouth a nesting place for decay and disease.

This is the opinion of the Educational Committee of the State Medical Society, which finds diseased teeth "The cause for many rheumatic troubles."

"By guarding the child's diet, correcting bad habits, keeping the child's first teeth in good condition and conserving the first permanent molar, the parent can assist greatly in preventing many of the cases of deformities and irregularities of the teeth and jaws," declares the bulletin of the State Medical Society issued today.

A recent survey of school children in one of the larger cities has disclosed the fact that forty per cent of them have crooked, irregular or malformed teeth and jaws.

"Some of the preventable causes of deformities of the teeth and jaws," the health bulletin points out, "are: premature loss of baby teeth through neglect; too long retention of the baby teeth after the time the permanent teeth are due; malnutrition suffered by children in early years; mouth-breathing as a result of adenoids and swollen tonsils; use of pacifiers, and thumb-sucking. These are some of the causes of dental deformities which the well-informed parent may easily avoid.

"Crooked teeth invite decay and pyorrhea, those two most dreaded dental troubles. The effect of crooked teeth upon the child's personal appearance and the frequent mental suffering in consequence are not to be thought of lightly. Clinical reports of many cases show improved records in school work and a greatly improved physical development as a result of corrective treatment of crooked teeth conditions.

"It is not necessary for the child to go through life with these deformities. Nature's mistakes and the effects of neglect may be remedied by orthodontic treatment. Facial contours may be restored, weak chins developed, protruding front teeth and irregular teeth may be coaxed back into proper alignment. Malocclusion, or faulty bite, due to these defects can be adjusted and made normal.

"It is a great mistake to delay orthodontic treatment until all the permanent teeth have erupted. The longer the case is delayed, the more complicated it becomes."

* * *

INSULIN

Madison, Wis., May 19.—That insulin is a price of life itself to many patients and that its administration is recognized by the State of Wisconsin is disclosed by the Educational Committee of the State Medical Society in a statement issued today. In Wisconsin the necessity of insulin for life and health has been recognized from an opinion of the Attorney General which authorizes county relief authorities to furnish insulin just as food and shelter are provided to those who cannot afford to buy them.

"The cost of the insulin is carefully regulated and is not excessive as compared with the cost of manufacture," declares the bulletin of the Medical Society. "It should never amount to more than about sixty cents per day for even the most extreme case of diabetes. In these individuals this cost is the price of life itself. In most diabetics the use of insulin so definitely increases health and strength that the cost is offset by increased earning power.

"It was recognized from the very first days of the injections of insulin in Toronto, where it was discovered, that a carefully measured diet must be employed along with the new treatment. Many diabetic patients have felt that the new and relatively easy hypodermic injections would make all exactness of dieting unnecessary. As a matter of fact, it is found that accurate following of diet rules is more necessary when insulin is to be used than when the diabetic is treated without insulin. The reasons are that the insulin is very powerful in making the body able to use sugar properly. If there is too much insulin or too little food the sugar which is available in the blood will all be used and the brain and muscles will be starved for this necessary food. The temporary con-

(Continued on page 416)

THE JOURNAL BOOK SHELF

Varicose Veins. With special reference to the injection treatment. By H. O. McPheeters, M. D., F. A. C. S., director of the Varicose Vein and Ulcer Clinic, Minneapolis General Hospital; attending physician New Asbury, Fairview and Northwestern Hospitals, Minneapolis. Illustrated with 62 halftone and line engravings. Third revised and enlarged edition. Price $4.00. F. A. Davis Company, 1914 Cherry Street, Philadelphia, Pa.

Primer On Fractures. By Cooperative Committee on Fractures, American Medical Association. Second Edition.

Surgical Pathology of the Skin, Fascia, Muscles, Tendons, Blood and Lymph Vessels. By Arthur E. Hertzler, M. D., surgeon to the Agnes Hertzler Memorial Hospital, Halstead, Kansas, professor of surgery, University of Kansas. 260 illustrations. J. P. Lippincott, Company, Philadelphia.

Psychology and Psychiatry in Pediatrics. The problem report of the subcommittee on psychology and psychiatry, Bronson Crothers, M. D., chairman. White House Conference on Child Health and Protection. Price $1.50. The Century Co., New York.

Body Mechanics: Education And Practice. Report of the subcommittee on orthopedics and body mechanics. Robert B. Osgood, M. D., Chairman. White House Conference on Child Health and Protection. Price $1.50. The Century Company, New York, New York.

Physicians Manual of Birth Control. By Antoinette F. Konikow, M. D., 1931, The Buchholz Publishing Co., 1501 Broadway, New York City.

History of Medicine in the United States. By Francis R. Packard, M. D., Editor, Annals of Medical History. In two volumes. Paul B. Hoeber, Inc., New York. Price, $12.00.

Gynecology and Urology for Nurses. By Samuel S. Rosenfeld, M. D., F. A. C. S. Adjunct obstetrician and gynecologist Lebanon Hospital, New York City; lecturer in obstetrics and gynecology to Lebanon Hospital School for Nurses; diplomate of the American Board of Obstetrics and Gynecology. Price $2.00 net. William Wood and Company, New York. 1931.

A Non-Surgical Consideration of Prostatic Enlargement. Including a lecture on the myth of the bladder neck bar. By Edwin W. Hirsch, M. D., associate in urology, College of Medicine, University of Illinois; urologist, Englewood Hospital, Chicago; member, American Urological Association, Chicago Urological Society, and American Medical Association. Price $2.00. Bruce Publishing Company, Minneapolis and St Paul, 1931.

Emergency Surgery. By John William Sluss, A. M., M. D., F. A. C. S., Associate professor of surgery, Indiana University School of Medicine, zone surgeon, United States Fidelity and Guaranty Company; consulting surgeon, City Hospital, and John Walter Martin, M. D., assisted by David Hart Sluss, M. D., and Camillus B. DeMotte, M. D. Fifth edition, revised and enlarged. 797 illustrations, some in colors. Price $5.00. P. Blakiston's Son & Co., 1012 Walnut St., Philadelphia.

Electrotherapy And The Elements of Light Therapy. By Richard Kovacs, M. D., clinical professor and director of physical therapy, Polyclinic Medical School and Hospital, New York; visiting physiotherapist, Manhattan and Harlem Valley State Hospitals and West Side Hospital; Consulting physiotherapist, Hackensack Hospital and Mary Immaculate Hospital, Jamaica, New York. Price $6.50. Illustrated with 211 engravings. Lea & Febiger, Philadelphia, 1932.

Clinical Roentgen Pathology of Thoracic Lesions. By William H. Meyer, M. D., professor of roentgenology in the New York Post-Graduate Medical School of Columbia University. Director of roentgenology in the New York Post-Graduate Hospital. Illustrated with 183 engravings. Price $6.00 net. Lea & Febiger, Philadelphia.

BOOKS RECEIVED FOR REVIEW

Practical Treatment of Skin Diseases. With special reference to technique. By Eduard Ahlswede, M. D., formerly assistant physician, University Skin Department, direction of Prof. Unna, Eppendorf Hospital, Hamburg; assistant physician, Clinic and Research Laboratory, direction of Prof. Unna, Hamburg; assistant physician, Institute of Physical Therapy, direction of O. Ahlswede, M. D., Hamburg. 77 illustrations. Price $12.00. Paul B. Hoeber, Inc., New York.

Diseases of the Coronary Arteries (Myocarditis). By Don C. Sutton, M. S., M. D., associate professor of medicine, Northwestern University; attending physician, Cook County Hospital; chief, Cardiac Follow-Up Clinic, Cook County Hospital, Chicago, and Harold Lueth, Ph.D., M. D., formerly instructor physiology, Northwestern University, Chicago. Illustration. Price $5.00. C. V. Mosby Company, St. Louis. 1932.

Human Sterilization. The history of the sexual sterilization movement. By J. H. Landman, Ph.D., J. D., J. S. D., The College of the City of New York. The Macmillan Company, New York, 1932. Price $4.00.

BOOK REVIEWS

Any scientific publication reviewed in this column may be obtained for inspection. Orders for such inspection should be directed to the Medical Library Service, 424 N. Charter Street, Madison, Wis.

Psyllium Seed: The Latest Laxative. By Dr. J. F. Montague medical director, Montague Hospital for intestinal ailments. Late of University and Bellevue Hospital Medical College; fellow American Medical Association; fellow New York Academy of Sciences; fellow New York Pathological Society; sometime fellow New York Academy of Medicine and American College of Surgeons. 20 illustrations. Montague Hospital for Intestinal Ailments, New York City. 1932.

The book contains 170 pages, divided into 12 chapters. It is well and for the most part entertainingly written. The author goes into the history of psyllium seeds and discusses other members of the

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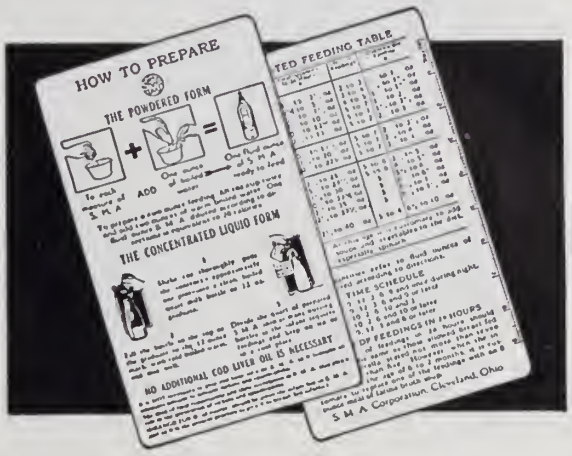

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Plantago family. There are photographic illustrations of the fields in cultivation, the plants and the seeds. Physical, chemical, pharmacological features are discussed.

One chapter is devoted to the medicinal value of the properties of psyllium and another to clinical experience with the seeds as a laxative. There are case reports and some general discussion of constipation. The author considers psyllium seeds superior to bran and mineral oil.

Supply, demand and marketing of the product are given considerable space. Physicians who properly treat constipation undoubtedly find the cause (which is herein admittedly important) and then regulate treatment according to the indications. Those who use psyllium seeds should read this book, although, contrary to the opinion of the author, it is hardly possible that these seeds (or anything else that must be purchased from a drug store) rightfully occupy anything more than a temporary and unimportant place in the treatment of constipation.

R. C. B.

Modern General Anesthesia: By James G. Poe, M. D., lecturer on general anesthesia in the Medical and Dental Departments of Baylor University; anesthesiologist of Baylor University Hospital of Dallas; consulting anesthetist to the Shriners' Hospital for Crippled Children, and Parkland Hospital, Dallas, Texas. Second edition, completely revised and enlarged, with 12 illustrations and 2 charts. Price $2.50. F. A. Davis Co., 1914 Cherry Street, Philadelphia, Pa.

The extreme scarcity of suitable modern textbooks in anesthesia for the student and practitioner probably excuses the publication of such a text regardless of how inefficiently or inaccurately it may be written. This book, revised in 1932, contains many inaccuracies and little attempt seems to have been made to bring it up to date. A chart representing "The Zones of the Third Stage of Ether or Ether Sequence Anesthesia With Signs in Each Zone" is pasted in the book as a frontispiece and copyrighted by the author in 1922. This chart bears some similarity to the well known chart long used by Guedel in teaching anesthesia and published by him in 1920 and revised in 1927. No objection is raised to the similarity. The failure to follow Guedel's outline of physical signs, however, leads the author to gross errors. One glaring mistake, among others, spoils the value of the chart in the reviewer's opinion. Both from the chart and the text, one gains the impression that the author believes the diaphragm to be progressively paralyzed as ether anesthesia is deepened until a point is reached when the diaphragm is completely paralyzed while intercostal activity continues. It is a well known fact, capable of being verified by very superficial observation, that the intercostal muscles are paralyzed during Guedel's third plane of surgical anesthesia and that the diaphragm becomes depressed during the fourth plane, reaching diaphragmatic paralysis as all respiratory effort ceases at the end of the fourth plane.

It is surprising to find a text book on anesthesia published in 1932 considering the subject of endotracheal anesthesia from the standpoint of insufflation. Endotracheal insufflation of anesthesia agents has been little used by modern anesthetists for the past ten years and is inefficient and non-physiologic compared with the use of to and fro endotracheal airways. The failure to mention the use of to and fro endotracheal airways in this text appears to indicate either carelessness or unfamiliarity with modern anesthetic literature.

The consideration of the non-volatile agents which have more recently come into use, such as avertin and the barbituric acid derivatives, contains no inaccuracies.

The chapter on local anesthesia would seem to add very little to the text since it contains no details and shows an evident lack of personal familiarity with local techniques on the part of the author.

The book as a whole adds nothing to that which is available in anesthetic literature. R. M. W.

Nutrition Service in the Field. Child Health Centers: A Survey. A Publication of the White House Conference. Price $2.00. The Century Co., New York.

This volume presents the finding and recommendations of two sub-committees of the Committee on Medical Care for Children of the White House Conference on Child Health and Protection.

The first part of the book is devoted to the report of the Sub-committee on Nutrition. This report is a study of nutrition work as part of the general program for child health and protection. It shows what is being done throughout the country by nutritionists (dietitians, home economists) in the field of child health and protection, presents information as to the training of nutritionists, considers the relationship and contribution of other public health workers to the nutrition program, considers ways of making nutrition an integrated part of programs for child health and protection, and makes recommendations as to what ought to be done and how to do it, in order to make optimal nutrition possible for the children of our country.

The second part of the book is devoted to the report of the Sub-committee on Child Health Centers. This report includes a review of an extensive survey of child health centers, an account of the nature and scope of these centers, and the recommendations of the Sub-committee for improving and extending this part of child welfare work. J. E. G.

Surgical Pathology of the Female Generative Organs. By Arthur E. Hertzler, M. D., surgeon to the Agnes Hertzler Memorial Hospital, Halstead, Kansas; professor of surgery, University of Kansas. 285 illustrations. J. B. Lippincott Company, Philadelphia.

The contents of this book can be found in most of the standard textbooks of gynecology and, in many

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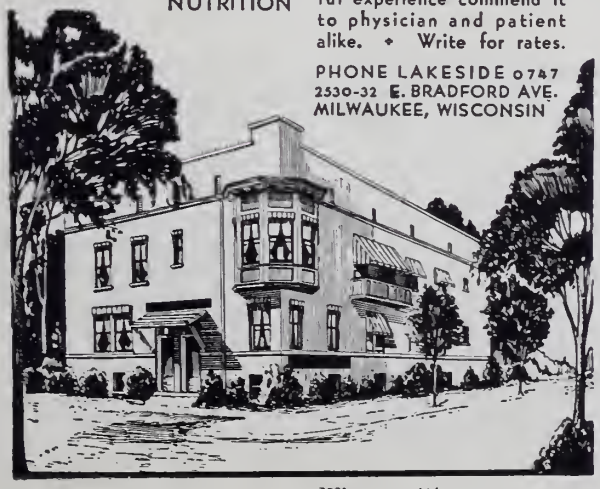

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instances, are there more thoroughly portrayed. It seems to the reviewer to add little to present day knowlege of the subject.

The author, however, is to be congratulated on his advocacy of conservatism in operative gynecology—an attitude, unfortunately, rare among general surgeons practicing gynecology. The illustrations are well chosen and accurate reproductions. J. W. H.

United States Army X-ray Manual. Authorized by the Surgeon-General of the Army. Second edition, rewritten and edited by Lt. Col. H. C. Pillsbury, M. C., U. S. A., Flexible leatherette, 500 pages, 228 illustrations. Price $5.00 net. Paul B. Hoeber, Inc., 76 Fifth Avenue, New York.

This new edition of the well-known U. S. Army X-ray Manual has many improvements over the first edition. Although no radical changes have been made in the general outline, the important developments in technic during the recent years are given full consideration. In a brief but concise manner the entire field of diagnostic roentgenology is covered. There are chapters on x-ray physics; dangers and protection; laboratory experiments; fluoroscopy; technique; field unit; localization; bones and joints; sinuses, mastoids and brain; teeth and maxillae; thoracic viscera; urinary tract and gastrointestinal tract. Numerous valuable suggestions will be found in the parts dealing with the interpretation of roentgenograms. The manual represents a valuable source of reliable information for the novice in roentgenology and even the specialist in this field can profit by its perusal. E. A. P.

PRESS SERVICE

(Continued from page 411)

dition which then arises is spoken of as an insulin shock or reaction. The brain is the most sensitive structure in the body. Under the conditions of sugar starvation from too much insulin, the brain attempts to get relief by causing hunger and making the individual nervous and irritable so that attention will be directed to the difficulty. If prompt steps are not taken to get sugar to the diabetic in this condition, the disturbances of the brain become more marked, and if they are allowed to go on too long, they may be dangerous.

"Some diabetics have refused to use insulin because they feared these insulin shocks. But the health-restoring power of insulin when properly used makes this objection lose its force. Furthermore these reactions are not dangerous if the patient is trained to recognize them as indications for more food. The reactions are very infrequent in those patients who are really accurate about the use of the diet and the properly measured doses of insulin. Dangerous reactions are almost never met with, excepting where the rules are violated.

"Some diabetics have thought that they could avoid these dangers by eating very liberally at all times. While that will avoid the reactions, it also prevents the highest usefulness of the insulin and it is therefore an uneconomical practice. A further danger is that when too much food is eaten by a diabetic his disease becomes worse, and he will then need more insulin. This was known to be true for many years before insulin was discovered, and it is still as true as ever."

INSULIN IN DIABETES

Madison, Wis., May 26.—Insulin is not a cure for diabetes, and the hundreds of patients who find no trace of sugar are not necessarily cured, is the opinion expressed by the Educational Committee of the State Medical Society in a statement issued today. Because thousands who use insulin find their condition improved is no indication that the disease is cured, the medical bulletin of the State Medical Society of Wisconsin today declares.

Because of the many requests received at the office of the State Medical Society for information on insulin, a special bulletin covering the use of insulin has been issued.

"The necessity for strictly following a measured diet as well as the use of insulin in one, two or three doses each day is often disappointing to those patients who hope to be cured in a few days from this ailment. Insulin is not a cure. There is probably no one who has been cured of diabetes by any sort of treatment. Many cures have been advertised, but these have been shown by the investigations of the American Medical Association to be frauds. No treatment or 'cure' for diabetes which is advertised should be taken without the supervision of a physician who understands the disease and the treatment. If there is any doubt about the genuineness and reliability of a method of treatment an inquiry should be sent to the American Medical Association in Chicago. All the medical men would be only too glad to learn of any simpler or better plan for the relief of diabetic patients. But so far the use of measured diets and the hypodermic injection of insulin are the only acceptable ways. Insulin cannot be taken by mouth with any success.

"Often diabetics call themselves cured because they find no more sugar in the urine. This condition is the proper one for all diabetics, but it does not mean a cure. It means that the disease is probably adequately under control. If the diet limitation is properly adjusted to fit the patients, and if the insulin doses are right the urine will remain free from sugar. But the patients must not think they are cured. For if they eat as much sugar and starch as ordinary individuals, sugar will promptly reappear in the urine.

"Fortunately most diabetics can remain free from sugar without insulin. They do not need insulin, and will not benefit from its use. There is often considerable improvement in the tolerance of the diabetic who follows his rules of treatment, with or without insulin, but this has never been known to amount to a complete cure. Therefore vigilance and careful dieting are needed for the entire life of the diabetic. But if the simple rules of dieting and using insulin are obeyed, life and health of the diabetic are as good as though diabetes did not exist."

TREATMENT OF PERNICIOUS ANEMIA WITH HORSE LIVER EXTRACT: PRELIMINARY REPORT

Oscar Richter, Arthur E. Meyer and Andrew C. Ivy, Chicago *(Journal A. M. A.*, May 7, 1932), have prepared an extract of horse liver which is low in total solids (1.8 Gm. from 100 Gm. of raw liver) and of which an oral administration induces a complete remission in pernicious anemia. A preliminary study of the comparative concentration or potency of the antianemia principle or principles active in pernicious anemia present in horse and cattle liver suggests that the concentration may be greater in the liver of the horse.

WHEN INDICATED AND WHY

PREGNANCY—Mead's Cereal has important amounts of practically every mineral present in the human body. It contains 0.22 Gm. Ca and 0.17 Gm. P per oz., and thus aids in protecting the mother's bones and teeth.

LACTATION—Containing 15% wheat germ, Mead's Cereal is rich in vitamin B complex, likely to be deficient in breast milk.

SECONDARY ANEMIA—Higher than any other food in iron and containing generous amounts of copper needed as a catalyzer, this palatable food has been shown to increase the hemoglobin.

INFANT FEEDING—With an antiscorbutic and Mead's Newfoundland Cod Liver Oil, Mead's Cereal supplies all vitamins and minerals needed for the first solid food.

COLITIS—Though rich in vitamins and minerals, Mead's Cereal has a low residue.

CALCIUM-PHOSPHORUS DEFICIENCIES—Mead's Cereal contains more calcium and phosphorus than most common foodstuffs.

VITAMIN B DEFICIENCIES—Mead's Cereal is helpful in correcting anorexia and spasticity in infants.

NORMAL PERSONS OF ALL AGES—No other food is so rich in such variety of minerals as Mead's Cereal. It thus becomes a valuable protective food for the normal individual as well as the sick.

Mead's Cereal is a delicious food that is relished by infants, children, and adults alike.
Write for samples and recipes for your household use.

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EXPERT TESTIMONY

(Continued from page 410)

tient, for he will not have given evidence which the opposite party may be able to refute overwhelmingly. It may be that many medical men think it will hurt their professional standing to state openly in court that they are not possessed of expert knowledge, although they may have been in practice but a very short time, and perhaps have not made the particular subject in question their specialty, but in the words of a recognized authority: "Eminence is not arrived at in a day nor without labor, and while we can expect only average knowledge and skill from the general practitioner or specialist, we have the right to expect the highest kind of knowledge from an expert". See: Herzog, *Medical Jurisprudence*, pp. 63 ff.

The practitioner who finds himself confronted with the problems so briefly discussed here should always keep in mind two things, and by anticipating them, ordinarily will not find himself in any predicament. First, he should remember that his relationship to his patient is confidential, and that transactions during such a relationship are privileged, the patient, except in certain circumstances, being the only one who can waive the privilege thus created. (See: sec. 325.21, Stats. of 1931). Secondly, the average attorney with whom he comes in contact will respect his wishes, insofar as possible, and will not seek to elicit information from the practitioner on the stand which will operate to the detriment of his client by asking the physician questions which he is not qualified nor prepared to answer. Clear advance understandings with the attorney involved as to the subjects which are properly part of the examination, as well as to special compensation where an extra amount of work is required, will frequently solve the problems of this nature which frequently confuse members of the medical profession.

Economic Survey of Wisconsin Hospitals Reported by Wisconsin Hospital Association at Chicago Meeting

An economic survey of Wisconsin hospitals was reported at the recent tri-state meeting of the Illinois, Indiana, and Wisconsin Hospital Associations held in Chicago late in April. While the survey is being completed, the data presented in Chicago included answers of fifty-eight of the hundred and twenty-seven hospitals and sanitariums to which questionnaires were submitted. The summarization is published herewith.

Questions 1–2–3

1. Total bed capacity, including bassinets_____No. of bassinets_____
2. What was your building and equipment cost per bed?_____
3. What is your total indebtedness on which you must pay interest?_____

Hospitals with less than 50 beds		Bed Capacity	Bldg. & Equip. Cost per Bed		Total Indebtedness	
14 Hosp.	Highest	40	9 Hosp.	$2844	13 Hosp.	$125,189
	Lowest	14		$1000		None
	Average	26.3		$2331		$ 25,796
	Total					$335,358
						$960 Ave. per Bed
Hospitals with 50–100 beds						
17 Hosp.	Highest	100	9 Hosp.	$5300	14 Hosp.	$ 350,000
	Lowest	50		$ 500		None
	Average	71.2		$2827		$ 112,416
	Total					$1,573,832
						$1,562 Ave. per Bed
Hospitals with more than 100 beds						
17 Hosp.	Highest	273	9 Hosp.	$5000	16 Hosp.	$1,300,000
	Lowest	105		$1550		None
	Average	152.5		$3374		$ 251,186
	Total					$4,018,978
						$1,652 Ave. per Bed

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Questions 4 and 5

4. Percentage of all occupancy in 1931_____Percentage of all occupancy in 1930_____
5. Number of obstetrical cases in 1930_____In 1931 _____

Hospitals with less than 50 beds		% Occupancy 1930	% Occupancy 1931	No. of Obs. Cases 1930	No. of Obs. Cases 1931
12 Hosp.	Highest	90%	95%	181	159
	Lowest	34%	28%	14	7
	Average	69.8%	65%	83.4	74.9
Hospitals with 50–100 beds					
15 Hosp.	Highest	84%	94%	434	424
	Lowest	37%	28.7%	88	82
	Average	60.3%	58.2%	224.8	221.4
Hospitals with more than 100 beds					
14 Hosp.	Highest	79%	72%	869	763
	Lowest	45%	37%	103	128
	Average	66.6%	58.6%	452.2	406.5

Question 7

7. Loss by bad debts in 1930_____Percentage of total_____
In 1931_____Percentage of total_____

Hospitals with less than 50 beds		Loss 1930		% of Total		Loss 1931		% of Total
Highest	9 Hosp.	$ 6,000	7 Hosp.	38%	11 Hosp.	$ 9,000	9 Hosp.	42%
Lowest		$ 1,039		3%		$ 772		6.1%
Average		$ 2,529		15.4%		$ 2,083		17.6%
Total		$22,767				$ 33,913		
Hospitals with 50–100 beds								
Highest	9 Hosp.	$11,744		23.33%		$ 18,943		25.16%
Lowest		$ 466		.002%		$ 247		.0018%
Average		$ 3,842		6.7%		$ 5,819		8.6%
Total		$34,580				$ 52,379		
Hospitals with over 100 beds								
Highest	10 Hosp.	$20,320		9.5%		$ 18,192		17.5%
Lowest		$ 779		.04%		$ 7,000		2%
Average		$ 7,849		4.58%		$ 10,918		6.83%
Total		$78,492				$109,183		

Question 14

14. What was your percentage of free work in 1930 ?____What did it represent in terms of money?_____
What was your percentage of free work in 1931 ?____What did it represent in terms of money?_____

Hospitals with less than 50 beds		% of Free Work 1930		Money Value		% of Free Work 1931		Money Value
Highest	7 Hosp.	20%	5 Hosp.	$ 14,000	7 Hosp.	30%	5 Hosp.	$ 23,000
Lowest		1.12%		$ 287		1.8%		$ 382
Average		11.08%		$ 3,587		13.4%		$ 5,460
Total				$ 17,937				$ 27,302
Hospitals with 50–100 beds								
Highest	7 Hosp.	8%	10 Hosp.	$ 9,705	7 Hosp.	9%	10 Hosp.	$ 15,200
Lowest		.05%		$ 500		.073%		$ 807
Average		3.9%		$ 3,154		4.9%		$ 4,186
Total				$ 31,543				$ 41,862
Hospitals with over 100 beds								
Highest	12 Hosp.	26%	10 Hosp.	$ 54,363	10 Hosp.	33%	10 Hosp.	$ 57,334
Lowest		1.5%		$ 2,130		2%		$ 2,583
Average		12.2%		$ 19,631		13.1%		$ 18,136
Total				$196,316				$181,368

PHYSICIANS' EXCHANGE

Advertisements for this column must be received by the 25th of the month preceding month of issue. A charge is made of $2.00 for the first appearance of copy occupying 1 inch or less of space and $1.00 for each succeeding insertion of the same copy. Kindly accompany copy with remittance to cover number of insertions desired. Advertisements from members of the State Medical Society will be accepted without charge. Such copy will be taken out after its second publication unless otherwise requested. Where numbers follow advertisements replies should be addressed care Wisconsin Medical Journal.

WANTED—Surgeon with 16 years experience, 4 years postgraduate work in Europe, desires group appointment or association with busy surgeon or general practitioner. Would consider purchase of practice. Address No. 867 in care of the Journal. AMJ

POSITION WANTED AS LOCUM TENENS. Will finish interneship July first. Available July, August and first two weeks in September. First two years at University of Wisconsin, graduate University of Kansas, and licensed in Wisconsin. Address No. 868 in care of the Journal. AMJ

FOR SALE—Office equipment, practically new. Hanovia quartz ultraviolet lamp; diathermy; zoalite lamp; office furniture, accessories, etc. Mrs. John Freedman, 2679 N. Teutonia Ave., Milwaukee. Telephone Hopkins 0739. JJA

FOR SALE:—10" direct current x-ray machine; dental chair, and Morse wave generator. Dr. Philip Eisenberg, 808 N. Third St., Milwaukee. Phone Marquette 0952.

WANTED—Soon, an unopposed or nearly so, location for general practice of medicine. No real estate. Address number 871 in care of the Journal. MJ

WANTED—Position by physician of 25 years experience to take practice of some physician who contemplates a six month's or a year's absence from his practice. City preferred but would consider country practice. Address number 878 in care of the Journal. JJA

WANTED—Eye, ear, nose, throat specialist wants association with physician and surgeon. Willing to assist in general practice. Address No. 873 in care of the Journal. MJ

POSITION WANTED—As superintendent of small hospital. R. N., Anes., 15 years' experience in Wisconsin and Illinois. Fully equipped. Address number 872 in care of the Journal. MJ

WANTED—Locum tenens work by capable physician; available for short or long period; Wisconsin license; references; will not compete. Address number 851 in care of the Journal.

MATERNITY HOME for unfortunate girls. Secluded, private. Rates reasonable. For information write to Box 120, R. R. 5, Baraboo, Wisconsin.

WANTED—Mayo trained surgeon and obstetrician wishes to buy practice in Wisconsin. Prefers town of three to seven thousand. Address number 869 in care of the Journal. MJ

PHYSICIANS WANTED—A surgeon and a specialist in EENT for group work in southwestern Wisconsin. Completely equipped office. Established practice. Percentage basis. Address number 874 in care of the Journal. MJ

FOR SALE—Practice, drugs, office equipment including new Allison table, etc., in town of 2500. South central Wisconsin in rich farming community. $450 takes all. Specializing. Address number 875 in care of the Journal. MJ

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ESTABLISHED LOCATION for sale in city of 23,000 on southern border of State. Deceased physician located in same office for 25 years with established practice. Office room for rent and equipment for sale. Address No. 877 in care of the Journal. JJA

WANTED—Locum tenens first three weeks in July. Northern Wisconsin only. Licensed in Wisconsin. Six years experience. Address No. 876 in care of the Journal. J

WANTED—Position as technician in hospital or clinic. General laboratory, Wassermann, blood chemistry, tissue sectioning and basals. Address Flora Schwefel, Oakfield, Wisconsin. JJ

Every why hath a wherefore.—Shakespeare. Why are "Storm" belts worn by patients in every civilized land? An eminent Stomach Specialist says, "They do all that you claim"

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Question 9

9. Did you reduce the number of paid employees in 1931? _____

9 hospitals with less than 50 beds have reduced number of paid employees.
9 hospitals with 50–100 beds have reduced number of paid employees.
9 hospitals with over 100 beds have reduced number of paid employees.

Question 10

10. Did you resort to salary reduction? _____ If so, what per cent? _____

Hospitals with less than 50 beds:
7 hospitals did not reduce salaries.
1 hospital reduced salaries—5%.
3 hospitals reduced salaries—10%.
1 hospital reduced salaries—15%.
1 hospital reduced salaries—25%.
1 hospital reduced salaries, but did not state amount.

Hospitals with 50 to 100 beds:
7 hospitals did not reduce salaries.
6 hospitals reduced salaries—10%.
1 hospital reduced salaries—20%.
1 hospital reduced salaries—50%.
1 hospital asked graduates to take a week's vacation, Dec. 1931.

Hospitals with more than 100 beds:
4 hospitals did not reduce salaries.
2 hospitals reduced salaries—5%.
1 hospital reduced salaries—7% approx.
1 hospital reduced salaries—10%–25%.
7 hospitals reduced salaries—10%.
1 hospital reduced salary, but failed to give amount.

Question 11

11. What economy measures did you put into effect in 1931? (If necessary use the reverse side for reply)
_____

Hospitals with less than 50 beds:
1 hospital more careful buying of supplies.
1 hospital less decorating, old linens used longer.

Hospitals with 50 to 100 beds:
1 hospital eliminated unnecessary repairs.
1 hospital installed a budget system.
2 hospitals careful handling of supplies.
1 hospital decreased office staff, preach and practice rigid economy.
1 hospital no improvements.
1 hospital closed one floor.
1 hospital careful purchasing, office economies.

Hospitals with more than 100 beds:
1 hospital closed one building.
1 hospital length of vacation reduced.
1 hospital closed first floor.
2 hospitals careful buying, check on supplies.
1 hospital eliminated building improvements.
1 hospital bartering; exchange of farm produce, labor, etc., is done continually; make drastic compromises to settle accounts.
1 hospital superintendent works part time, having secured part-time employment.
1 hospital reduced vacation period from a month with pay to 2 weeks without pay and 2 weeks with pay.
1 hospital always careful of waste.
2 hospitals very careful management.
1 hospital supervisor given additional work.

Question 12

12. By what means did you attempt to increase your revenue. i. e., through pharmacy, laboratories, independent fund raising, etc.? _____

Hospitals with less than 50 beds:
1 hospital by better service.

Hospitals with 50 to 100 beds:
1 hospital impossible to increase charges in any department.
1 hospital attempt to increase revenue by social parties.
1 hospital attempt to increase revenue only by trying to offer service that will induce patients to avail themselves of this service when necessary.
1 hospital organized diagnostic group rates.
1 hospital principally by advertising in Medical Journal.
1 hospital independent fund raising.

Hospitals with more than 100 beds:
1 hospital only through better service.
1 hospital independent fund raising.
1 hospital "Our personal friends have stood by us".
1 hospital Donation Day and Ladies Auxiliary.
1 hospital reduced room rates.
1 hospital practically impossible to attempt increasing revenue.
1 hospital field worker soliciting gifts of money, produce, etc.

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Question 13

13. Do you contemplate any additional building in 1932? If so, what will be the nature of it? _____

Hospitals with less than 50 beds:
10 hospitals do not plan any additional building in 1932.
1 hospital plans to install an elevator.
1 hospital plans a fireproof unit of 20 beds.

Hospitals with 50 to 100 beds:
13 hospitals do not plan any additional building in 1932.
1 hospital refrigeration system.
1 hospital new addition of 60 adult beds opened April 15, 1932.

Hospitals with more than 100 beds:
15 hospitals do not plan any additional building in 1932. (1 hospital "all ready too much room").

Question 16

16. What rates have you lowered? _____

Hospitals with less than 50 beds:
1 hospital all rates lowered 20%.
1 hospital rates lowered on extras such as drugs & x-rays.
1 hospital room rates lowered, give 10% for cash when leaving hospital.
1 hospital lowered private rooms.
1 hospital ward rates and better private rooms lowered.

Hospitals with 50 to 100 beds:
1 hospital private room rates lowered.
4 hospitals reduced all hospital rates.
1 hospital "We consider the individual".
1 hospital lowered tonsillectomy rates.
1 hospital established a "flat rate" for obstetrical cases—a reduction of 75¢ per day.
1 hospital wards and double rooms.
1 hospital lowered obstetrical rates.
1 hospital lowered room rates slightly.
1 hospital "flat rate" for obstetrical cases—nine days for $50.

Hospitals with more than 100 beds:
1 hospital lowered room and board.
1 hospital lowered rates for dressings.
1 hospital room rent and surgical service lowered.
1 hospital reductions occasionally, rates are all ready low.
1 hospital lowered only "forced rates" through county and city.
1 hospital lowered rates for rooms, laboratory and anaesthetic.
1 hospital inaugurates flat obstetrical rate in wards for $37.50.
1 hospital "our rates are lower now than most hospitals".
1 hospital lowered operating room service for tonsillectomies from $3 to $5.
1 hospital 10% discount on rooms.
1 hospital allowed 5% discount for cash.

Question 17

17. What changes have you made in your Nurses' Training School since Jan. 1, 1931? (Discontinued school, cash allowances, increased or decreased number of pupils.)

Hospitals with less than 50 beds:
1 hospital discontinued school.
1 hospital no accredited training school.
1 hospital decreased number of pupils.

Hospitals with 50 to 100 beds:
1 hospital discontinued cash allowances, decreased number of pupils.
2 hospitals discontinued training school.
1 hospital no changes.
1 hospital discontinued cash allowances 1 year ago.

Hospitals with more than 100 beds:
1 hospital decreased number of students, considering discontinuance of school.
2 hospitals decreased number of students.
1 hospital cash allowances discontinued in 1929, students decreased, no class in February, 1932.
1 hospital decreased allowances.
1 hospital decided to discontinue Nurses' Training school September 1, 1932.
1 hospital discontinued cash allowances.

Therapeutic Notes

New and Nonofficial Remedies

In addition to the articles enumerated in the May issue the following have been accepted:

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Medical Science Course The medical science course covers two years of college work in English, foreign language, physics, chemistry and biology and two years of work in the basal medical sciences, anatomy, histology, neurology, physiology, physiological chemistry, pathology, bacteriology, pharmacology, hygiene and diagnosis. This course leads to the B. S. degree.

Medical Course At least two years of college work, including English, foreign language, physics, chemistry and biology, are required for admission. The course requires at least four years for completion. During the first two of these years the work lies chiefly in the basal medical sciences outlined above. The third year of the course is devoted to didactic and practical instruction in the wards and out-patient department of the Wisconsin General Hospital. The fourth year of the course is devoted to practical instruction under the supervision of preceptors in the Wisconsin General Hospital and in affiliated institutions.

Courses in Nursing Courses in nursing are offered in the School of Nursing affiliated with the medical school. A residential course of 32 months is offered in the Wisconsin General Hospital to those who have completed a semester of specified work in the College of Letters and Science. This course leads to a certificate of graduate nurse. A residential course of 27 months is offered to those who have completed three years of college work in specified subjects either in the College of Letters and Science or in the Department of Home Economics. These courses lead to a certificate of graduate nurse and to a B. S. degree.

Graduate Courses Opportunity is offered for graduate work in the preclinical and the clinical medical sciences and in hygiene and public health. For further information address C. R. Bardeen, Dean, Medical School, Madison, Wis.

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Instruction The course of instruction extends through a period of five years and leads to the degree of M. D., the fifth year being devoted to hospital internship. Each annual session begins the first of October and ends about the middle of June. Particular emphasis is laid upon practical work in the anatomical, chemical, physiological, pathological, and surgical laboratories. A dispensary is maintained by the Medical School, in which ample opportunity is afforded for practical instruction in all branches of medicine and surgery.

Clinical Facilities Medical and surgical clinics are conducted in Milwaukee County Hospital, and in a number of city hospitals, thereby affording adequate facilities for imparting bedside instruction under scientifically competent and experienced staffs.

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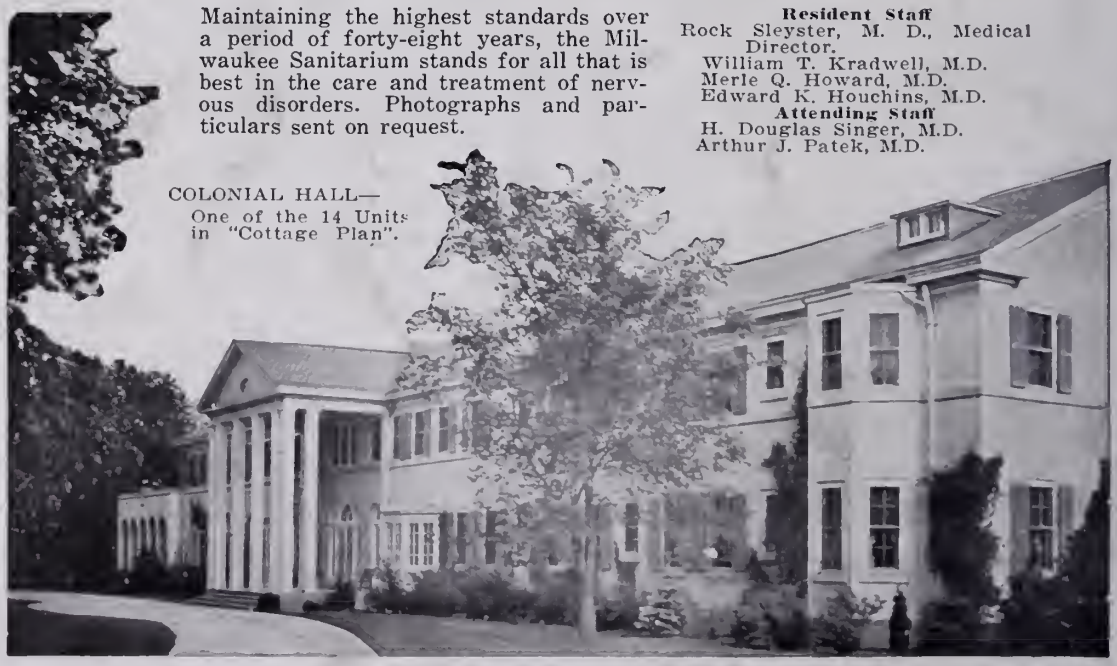

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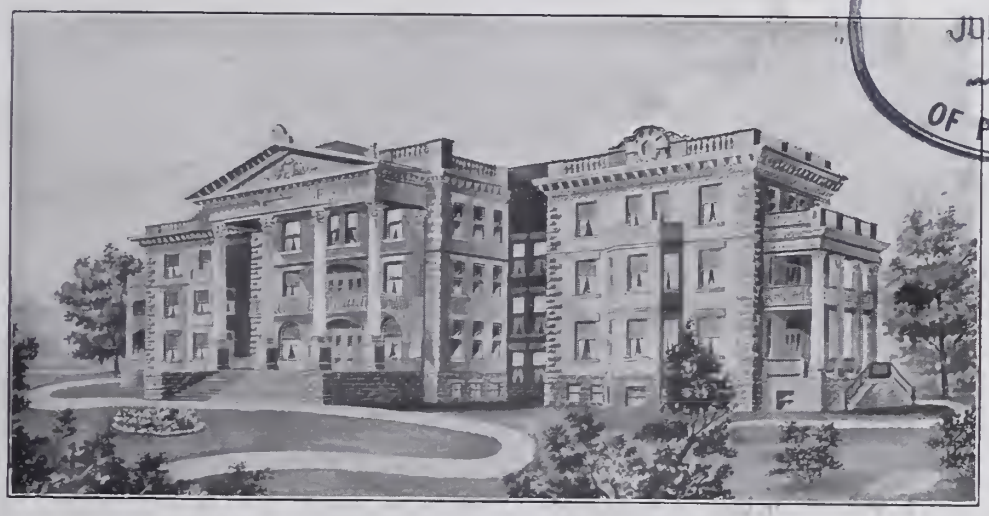

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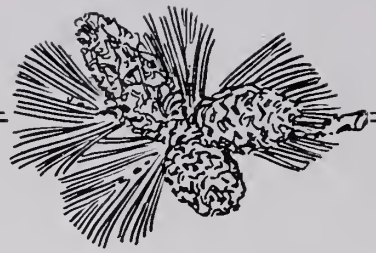

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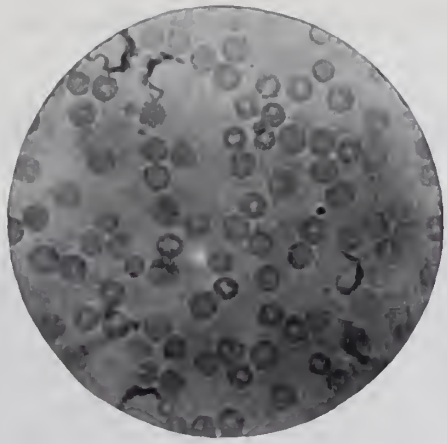

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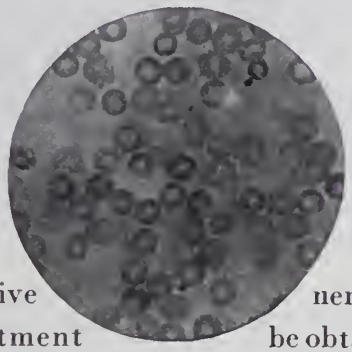

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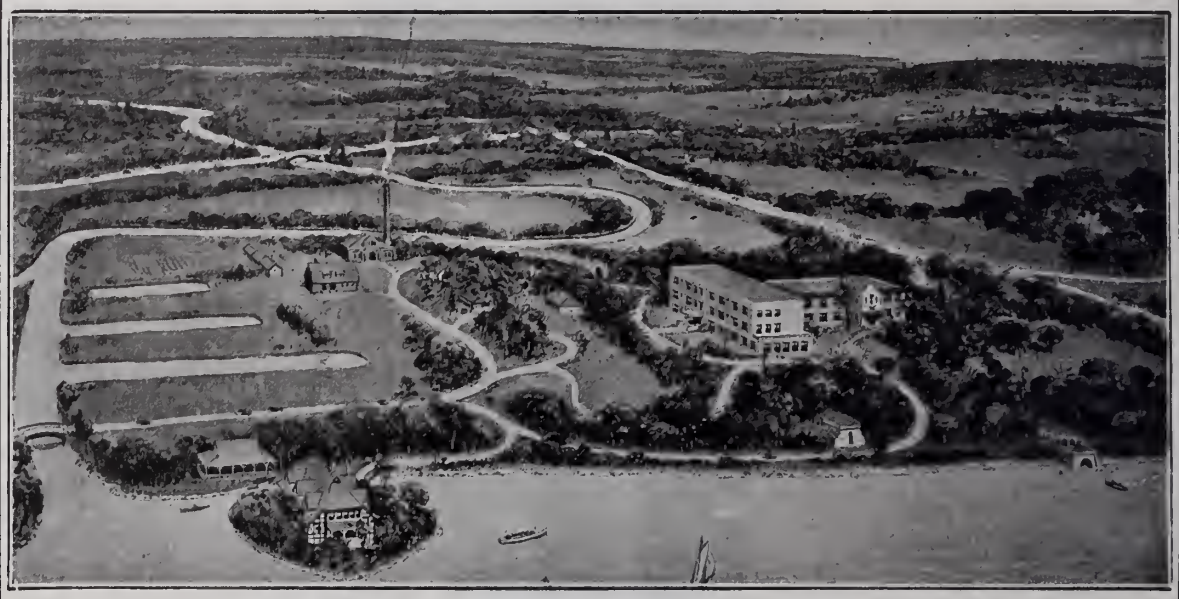

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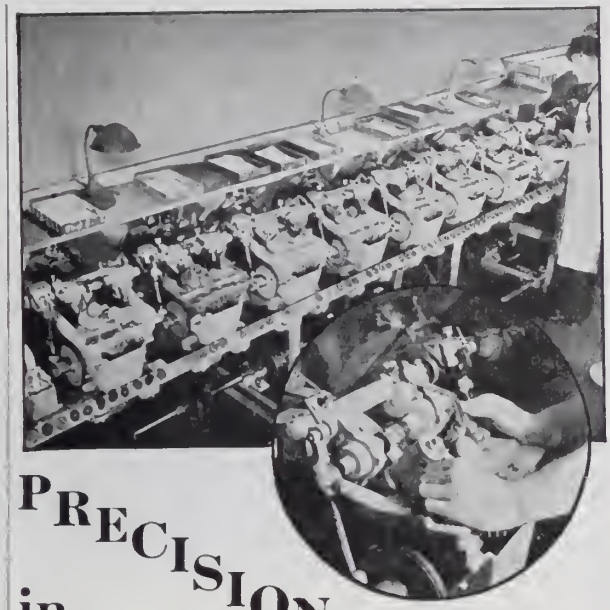

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The Small Town Physician in General Practice and His Relationship to the Medical Profession*

By JOHN H. KARSTEN, M. D.
Horicon

The grand old "Country Doctor", has been painted, penned and panned and all of the efforts in his behalf have resulted in a great deal that is good and a great deal that is ridiculous. We will endeavor, in this paper, to set forth that side of the country practitioner's problem that should hold greatest interest for members of the medical profession, namely,—his place in that profession.

We have chosen to define "small town", for our purposes, as that municipality having a population of 5,000 or less, inasmuch as we believe that by so limiting ourselves we can hew more closely to the line.

The professional press, as well as the lay press, has given much space of late to the family physician. Many medical authorities, economists, and widely known literary contributors seem quite generally agreed that the family doctor has a very definite and very essential place within the science of medicine as it is now established and as it is now practiced. With all this accord as to the comparative importance of the family physician there seems to be as general an assumption that his specie is vanishing. His going is viewed with alarm, and the maintenance of his specie is devoutly prayed for. But with so many alarms sounded during these days of depression, gang rule, and communism each loses its individual urgency and consequently its individual solution. Of one thing we may all be assured, that unless the problems of our profession are met squarely and energetically by its own members, they will not be solved with greatest advantage to the profession and to the public which it serves; and again, unless the general practitioner establishes general practice as a very definite entity within the science of medicine, then general practice will not survive.

I have stated that the justification for the existence of the general practitioner has been rather generally accepted and now I emphasize *RATHER* generally. I will quote from the recent address of a recognized medical leader and educator:

> "The general practitioner was the big man in medicine 30 years ago. Today he is in an unfortunate position for many reasons. He is the only doctor who has little leisure and therefore finds it hard to keep abreast of modern medical literature. Even if he had the time, his work covers all branches of modern medicine and no man can have an intimate understanding of all branches of modern medicine.
>
> "His economic plight is even worse. If he is conscientious, he sends a large number of patients to specialists and calls for consultations for a large percentage of the remaining patients. This makes of him a receiving clerk who is continually distributing patients to various specialists.
>
> "This condition will probably correct itself. The graduate of today is equipped for practice in a manner undreamed of 30 years ago. He will be somewhat of a specialist even if he attempts to go into general practice. He will have leanings toward a certain specialty; will maintain his knowledge of literature on this specialty; will treat all the patients who come under that classification and will even receive referred patients in that specialty from neighboring doctors, as he grows older. The general practitioner is probably doomed even in remote districts. This is particularly true of the next generation.

* Presented before 90th Anniversary Meeting, State Medical Society of Wisconsin, Madison, Sept. 1931.

We are building so many roads that there will be no remote districts."

I believe that this thought is worthy of our very painstaking analysis.

Dr. Judd, the past president of the American Medical Association, has said quite recently that no physician-patient relationship will ever be more essential in the prevention and cure of disease than that contact which exists between family physician and patient. I have in mind the case of a 58 year old man. He had worked hard, his material acquisitions and his accomplishment in the line of his endeavor were noteworthy. Under the care of his family physician a diagnosis of gall bladder disease with calculi was made, but immediate surgical intervention was deemed inadvisable inasmuch as the case presented no single acute or emergency symptom. Furthermore it was the opinion of the family doctor that this man was a most undesirable surgical risk and he based his opinion upon his knowledge of the patient's habits; the patient's susceptibility to transitory nose, throat and sinus infections and his inability to recover normally from the effects of these infections. He knew that the patient's toleration for the cold of winter and the heat of summer was unduly low compared to average toleration. In short—he knew his man. For these reasons the family physician recommended a six-week period of enforced rest, away from the cares of work and the joys of recreation, prior to any surgical procedure. The patient did not see fit to give this prolonged period from his all too busy life. He presented himself at one of our largest American clinics, was operated, and delivered of two very small gall stones. Post operative pneumonia and post operative kidney involvement, neither of an alarming nature, caused his death. If this case proves nothing else, I believe that there can be no question that this man's family physician was in possession of knowledge that no clinic, no group, nor any specialist can ever duplicate.

RURAL SERVICE

About 42% of our country's population is rural, thus we have approximately 50 million persons largely dependent upon the small town for their medical care. I say largely dependent because the finances of our rural population are such that the average individual must accept first that care which is nearest at hand and consequently most economical. Good roads and rapid transportation may bear very directly upon remoteness but they can never entirely merge city and country. To what group or specialist shall we refer our periodic examinations, our routine immunizations and regular preventive practices, not spectacular perhaps but definitely essential to well-being? The person suffering from any pathological condition of unquestioned seriousness is a likely candidate for the clinic; the apparently well individual is not prone to give excessively of his time or his money. Hospitalization for child birth is becoming more common every day but I cannot conceive that it will ever be economically possible that all children be born in hospitals. Emergency and industrial problems will always confront the small town physician and the original care given in these cases is so essential in their final outcome. Cases of communicable diseases cannot be transported nor are there any isolation hospitals except in very large cities. The group, the clinic, and the specialist are most ably and nobly discharging a most important portion of the medical profession's obligation, but that obligation extends beyond the realm that our present distribution of population permits them to reach. It has been said that the progress in the science of medicine is immeasureable, but, that during the last two decades the art of medicine has advanced not at all.

The small town is a fixed and permanent unit of our national structure and its surrounding agricultural or industrial community is inevitable. Small towns may die but more will be born and they will always (I hope always) have doctors. What then is the relationship of the small town physician in general practice to the medical profession? A fourth cousin twice removed by marriage—I am afraid—.

The grand scheme of medicine, including medical education, is assuredly moving away from the general practitioner and most assuredly from the small town practitioner.

The general man of the larger city has hospital facilities, consultation opportunities, and professional society relationships that are not available to the small town family doctor. The city man may have little or much equipment according to his financial ability, but what equipment he lacks is readily available. The country man, due largely to economical reasons, cannot be elaborately equipped and consequently should have the aid of every known resource to develop his senses and his mind. Now it is my opinion that neither our medical schools nor our medical literature is giving the general practitioner the fundamental necessities to make him adequate within his field and perhaps the reason for this is that his field is so poorly defined.

If the established medical education and the established medical organization of this country have chosen rural America as a proving ground and source of experience for its subsequently famous physicians, then it is my humble opinion that they are failing to discharge a rounded and balanced obligation to America's well-being. The engineer may well leave the small town for it will never have Chrysler buildings nor Brooklyn bridges, in fact, in every other field of endeavor it is quite natural to go to that center in which opportunity of achievement is most abundant, but I believe (if we are to be at all idealistic) *OUR* obligation is exactly the same to every unit of our entire national structure.

FUTURE PRACTICE

I am not going to discuss the relative value of specialization; we all know that its basis is entirely rational and that its achievements have the glory of work well done. Nor am I going to dwell upon the small town doctor's problems of hospitalization, consultation, referred cases, et cetera; his economical life and his professional dealings are familiar to all of you. I will suggest, however, that it is economically sound and professionally desirable to attempt (within our profession) to give small town general practice the quality of permanent achievement rather than its present tendency toward transitory experience.

How shall we do this?

1. Choice of men. Certainly there are men as truly fitted for rural general work as for any other field in the profession. At present many such men fear that so choosing their field is an admission of lack of ambition or inability to cope with more spectacular competition. This can best be eradicated by recognition of the field by the profession.

2. Medical education. For very obvious reasons state medical schools have an obligation unlike heavily endowed schools and I believe that state schools primarily should train men to practice rather than to specialize. Postgraduate training for the general man is under way but is entirely inadequate and an element of that training which I believe is sadly neglected is giving the physician a sound basis upon which to build judgment. Let me explain:—We will say a postgraduate course in fractures, for the general practitioner, is offered. In the discussion of a simple Colles' fracture full treatment is given in detail, but in the case of a fracture that is grossly pathological and difficult, the treatment is: transportation splints, hospitalization, orthopedic surgeon. Your student is thereby better equipped to conscientiously discharge his duty and he is not encumbered with a lot of information that he cannot utilize to his patient's best interest.

3. The organized medical profession must more firmly embrace general practice. Avenues must be opened for the professional recognition of the country doctor. Medical literature must have space for his achievements for it is quite natural that the country doctor wants recognition from his colleagues rather than the poetic, palsied, provincial, picture that the public has painted.

CONCLUSION

Paternalism by state and by nation has entered many fields and its basis of entrance is always economics. As a profession we do not want paternalism and as a profession we are doing our best to correct every economic ill with which we may justly be charged. Adequate first care has immeasurable bearing upon the course and cost of being sick and first care for many years to

come will be dispensed either by the family doctor or a public agent.

Good roads, automobiles, snow plows, and similar improvements have eliminated many of the country practice hardships which are quite generally believed to exist. With these accessories the small town physician has the opportunity of sufficient work and a normal amount of leisure. The medical profession has consciously and unconsciously given glory and honor to special achievement but it has done little toward making general work attractive.

The generalities of this paper are unsatisfactory inasmuch as it contains many specific problems worthy of detailed consideration. So, too, is country practice general, but if the same amount of planning and consideration was given to this field as is given to any special field, we would have (as has been suggested by the president of our State Society) a new specialty—The General Practitioner.

The Anaemias of Adolescence; Clinical Diagnosis, Pathology and Treatment*

By HAROLD R. FEHLAND, M. D.
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The anaemias present a group of conditions unequalled in their ability to tax the diagnostic acumen of the medical consultant. In many of them, as for example the leukemias, the blood picture tends to establish the diagnosis, but in others the blood findings merely lead to a suspicion of the underlying disease. In still others, the splenomegaly, the spontaneous hemorrhages, the swollen joints or the enlarged superficial lymph nodes may be the most prominent objective findings. Considering all these factors, there can be little doubt that, when seeing a patient with a definite anaemia, the highlights in the differential diagnosis of these blood dyscrasias must constantly be kept in mind.

DIAGNOSIS

The problem of the anaemias of adolescence is closely interwoven with that of the spleen. The clinical phenomena may not always readily reveal this relationship, but in a great many instances it is the pathologic spleen which serves as the underlying cause of a severe anaemia. As W. J. Mayo[1] has said, "Physiologically the spleen is not important, but pathologically it is a menace, because splenic enlargement of itself increases a function which is not significant, to an overactivity which is not easily controlled through natural agencies". Since the spleen is a part of the reticulo-endothelial system to which also belong the other lymphoid tissues of the body, it follows that the spleen reaches the height of its activity during adolescence and therefore also appears to be more subject to pathologic processes during this period. The most common disease process is that which functionally produces a work hypertrophy and is usually associated with anatomical hypertrophy as well. The result of such changes is commonly an increase in the normal physiologic function of destroying formed blood elements, whether these be red blood cells, as in hemolytic icterus, where these cells are abnormally fragile, or white blood cells as in early Banti's and Gaucher's disease, or even platelets as in purpura hemorrhagica. At other times the pathologic spleen resumes certain foetal characteristics in the production of embryonic white blood cells, bringing about the clinical syndrome known as myelogenous leukemia. In all of these conditions there obtains a fundamentally malfunctioning spleen, and the ultimate clinical phenomenon is that of an anaemia.

CLASSIFICATION

Since the clinical picture, as well as the treatment, of many of these anaemias is almost identical, it is best, for reasons of simplicity, to group them as much as possible. The purpuras may best be classified as thrombopenic and nonthrombopenic. Purpura hemorrhagica and aplastic anaemia come under the head of thrombopenic, whereas such conditions as Schönlein's arthritic

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purpura, Henoch's abdominal purpura, purpura simplex, and hemophilia would necessarily be termed nonthrombopenic. The anaemias associated definitely with splenic enlargement, of which Gaucher's, von Jaksch's, Banti's disease and hemolytic icterus are the outstanding examples, are best classed as the splenic anaemias. Besides these, there are the specific anaemias due to tuberculosis, syphilis, acute infections such as typhoid fever, toxic agents, and intestinal parasites. This group must be differentiated from pernicious anaemia, from the condition called chlorosis, and from secondary anaemia due to hemorrhage. Aside from all these types we have the anaemia of Barlow or infantile scurvy, Hodgkin's disease, and, in order that the classification be complete,—the leukemias.

TREATMENT

The treatment also offers considerable interest not only from the medical but also from the surgical standpoint. With the advent of liver and stomach extracts in the treatment of various anaemias, the prognosis, as well as the indications for surgical intervention, have been considerably altered. Medical therapy has again obtained a stimulus to the extent that new as well as old and discarded remedies have been given therapeutic trials with at least partial success, the most important of these compounds being the salts of iron and copper together with calcium, the various hormones and the vitamins. Surgically, the transfusion with whole or citrated blood, as well as splenec-

THE PURPURAS

THROMBOPENIC		NON-THROMBOPENIC	
PURPURA HEMORRHAGICA	APLASTIC ANAEMIA	HEMOPHILIA	PURPURA SIMPLEX
I. Cutaneous hemorrhages	I. Cutaneous hemorrhages	I. Males only (Rarely females)	I. Mild subcutaneous hemorrhages
II. Mucous membrane hemorrhages	II. Mucous membrane hemorrhages	II. Transmitted through female	
III. Anaemia	III. Anaemia	III. Due to prothrombin deficit	PURPURA ARTHRITICA (SCHÖNLEIN)
IV. Platelet reduction	IV. Leukopenia with relative lymphocytosis	IV. Coagulation time increased	I. Cutaneous hemorrhages
V. Delayed bleeding time	V. Platelets reduced in late stages	V. Cutaneous hemorrhages	II. Joint pains (Swollen joints)
VI. Non-Retractile clot	VI. Coagulation time prolonged	VI. Mucous membrane hemorrhages	Due to: Serous effusions Hemorrhage
VII. Normal coagulation time	VII. No regenerative R. B. C. in blood stream	VII. Bleed following surgical procedure	
VIII. Almost limited to children	VIII. Hypoplastic bone marrow	*Treatment*	PURPURA ABDOMINALIS (HENOCH)
IX. Embryonic types of R. B. C. in circulation after hemorrhage	*Treatment*	I. Prophylactic	I. Intestinal colic (Hemorrhages)
X. May be acute–subacute–chronic	None	II. Palliative	II. Joint pains
XI. May be congenital	(Do not respond to transfusion)		III. Cutaneous and mucous membrane hemorrhages
Treatment	*Prognosis*		CAUSE: Probably due to a toxic capillary paralysis with dilation and diapedesis May be anaphylactoid
I. Transfusion A. Liver extract B. Iron citrate C. Cod liver oil et phosphorus D. Calcium	Death		
II. Splenectomy			
Prognosis			
Good			

tomy in selected cases, offers the most striking benefits.

MEDICAL

Medical management consists of three types,—curative, palliative and pre-surgical. Treatment directed toward conditions which are von Jaksch's and Barlow's syndromes, termed curative. Most important of these are von Jaksch's and Barlow's syndromes, pernicious anaemia, the specific anaemias, and many secondary anaemias due to hemorrhage of known or unknown etiology, the most important being the early menorrhagias. Von Jaksch's and Barlow's diseases apparently have a nutritional disorder as their underlying etiologic factor, and therefore adequate vitamin supply plus hemopoietic stimulants such as liver, dessicated stomach, calcium and iron are indicated. Such blood-forming stimulants, with the addition of deficiency medication and occasional transfusions, also cover grossly the field of therapy in pernicious anaemia. It goes without saying that in the specific anaemias the treatment must be directed toward removal of the underlying cause. In the anaemias due to hemorrhage of one kind or another the initial cause must be sought and treated primarily, and it is in those associated with the menstrual cycle that hormone therapy has been of some value.

Palliative medication is so classified because it is that form of treatment instituted in the leukemias, Hodgkin's disease, hemophilia and allied conditions for which there is no cure and where, hemophilia excepted, the mortality is 100%. It is of interest to note that in all these anaemias the palliative treatment par excellence is radiation. In

TABLE II

Von Jaksch's	Gaucher's	Banti's	Hemolytic Icterus
I. Splenomegaly (Sharply marginated)	I. Splenomegaly + + + +	I. Splenomegaly + + +	TYPES 1. Congenital (Mild–chronic) 2. Acquired (Acute)
II. Leukocytosis (relative lymphocytosis) Probably due to extension of erythroplastic parenchyma of bone marrow to spleen, liver, etc.	II. Large liver + +	II. Liver + or — (Portal or Laënnec type of cirrhosis)	I. Splenomegaly
III. R. B. C. decrease	III. Leukopenia	III. W. B. C. reduced or normal	II. Large liver
IV. Anaemia	IV. R. B. C. decrease	IV. R. B. C. decrease	III. Acholuric Jaundice I. E. Negative urine and stools
V. Poikilocytosis nucleated R. B. C. basophylic granulation	V. Anaemia	V. Anaemia	IV. R. B. C. fragility
VI. Dull yellow pallor with subcutaneous edema	VI. Large multinuclear reticular cell in spleen and liver	VI. Ascites	V. Crises A. Urobilinuria B. Embryonic types of R. B. C. in blood stream
VII. Usually under 3½ years	VII. Familial tendency	VII. Jaundice	VI. High duodenal pigment values
VIII. Frequently rachitic	VIII. Girls 7–1	VIII. Hemorrhagic tendency. Gastric hemorrhages	*Treatment*
IX. Hemorrhage is rare	IX. Second decade	*Treatment*	Splenectomy
Treatment	*Treatment*	Splenectomy	*Prognosis*
Treat the underlying cause	Splenectomy?	*Prognosis*	Good
Prognosis	*Prognosis*	Good if in early stage	
Good	May live 25 years +		

HODGKIN'S	BARLOW'S (INFANTILE SCURVY)	CHLOROSIS (?)	LEUKEMIAS
I. Painless multiglandular adenopathy A. Non-suppurative B. Matted together II. Spleen + or negative III. Leukocytosis relative polymorphonuclear type IV. Fever and malaise V. No hemorrhages VI. Biopsy of lymph node A. Dorothy Reed cell (large endothelial cell) B. Marked fibrosis *Treatment* X-Ray *Prognosis* 2–20 years	I. Subperiosteal hemorrhages (Femur chiefly) N. B. May produce exophthalmos if under orbital periosteum II. Subcutaneous hemorrhages III. Hematuria 10% IV. Stomatitis V. Secondary anaemia *Treatment* Fresh, whole, untreated milk *Prognosis* Good	I. Anaemia + + II. Reduced R. B. C. + + III. Girls 10–1 IV. No liver or spleen changes V. Merely the symptoms of a severe anaemia *Treatment* Treat the cause— 1. Tuberculosis 2. Nephritis 3. Goitre 4. Nutrition 5. Environment *Prognosis* Good	I. Lymphocytic A. Acute B. Chronic II. Myelogenous A. Acute B. Chronic **SPECIFIC ANAEMIAS** I. Tuberculosis II. Syphilis III. Toxic IV. Acute infections A. Typhoid fever V. Intestinal parasites **PERNICIOUS ANAEMIA** SECONDARY TO HEMORRHAGE

leukemias this mode of palliation may produce remissions over a period of years. Patients with Hodgkin's disease have been known to live 20 years after the original diagnosis was made. The type of treatment in hemophilia is, of course, entirely prophylactic and symptomatic.

Pre-surgical treatment consists of a combination of all the above mentioned methods and is used chiefly in the pre-operative preparation of patients suffering from extreme degrees of anaemia who cannot be immediately operated upon, although their condition may be primarily surgical. In this category belong also those cases having acute hemorrhages which require early control. The intramuscular injection of whole blood as well as the subcutaneous injection of snake antivenin[2] has been found to be of great value in such emergencies.

SURGICAL

The anaemias amenable entirely or in part to surgical procedures are grossly those which are associated with splenic enlargement. There are two exceptions to this rule,—von Jaksch's disease which is best treated medically, and hemorrhagic purpura which, though strikingly susceptible to surgery, does not always have an associated splenomegaly. The conditions which are benefited most by splenectomy are thrombopenic purpura hemorrhagica, hemolytic icterus, early Banti's disease, and sometimes that peculiar form of splenic anaemia known as Gaucher's disease.

Thrombopenic purpura responds to surgical treatment more dramatically than any other of the anaemias. Since Kaznelson[3] in 1916 performed the first splenectomy for purpura, there have been reported approximately 160 cases. The prognosis in the various series which make up this total of 160 case reports was uniformly good. In Washburn's[4] series of 48 cases, including 32 previously reported by Spence[5], and composed of children under the age of 16 years, the percentage of complete cures was 70.7 with improvement in an additional 16.8%. The mortality in this entire series was 8.3%. Such good results are somewhat modified when Washburn's statistics upon adult patients are reviewed. In a series of 84 cases, including those collected by Whipple[6] and Spence[5], plus 28 which he himself tabulated, the reported good results dropped to 60.2%

with improvement in an added 13.3% and a mortality of 18.8%. Such findings are also borne out by statistics at the Mayo Clinic, where Kennedy[7] reported 7 splenectomies for thrombopenic purpura in children under 14 years with good results in all of them and no fatalities, as contrasted to a mortality of 3.1% in a series of 32 cases including adults, reported by W. J. Mayo[1]. The conclusions from such figures are obvious,—splenectomy following adequate pre-operative preparation should be performed whenever the diagnosis of thrombopenic purpura has been established, and better ultimate results can be expected in the early than in the late cases.

Hemolytic icterus, especially that form which is known as the acquired type of Hayem and Widal, is the most important "splenic" anaemia responding to extirpation of the spleen. The other, or congenital type of Minkowski, is usually quite mild in character and rarely needs treatment. The first splenectomy for hemolytic icterus was performed by Sir Spencer Wells in 1887[8]. Twenty-seven years later Lord Dawson[8] saw this patient alive and well but still having a residual red cell fragility. After splenectomy, the patients show immediate improvement. The jaundice disappears; they no longer have periods of malaise and fever; there is no further tendency toward mucous membrane hemorrhages and the patient, for the first time in his life, in many instances, feels well. There is, however, one exception to the disappearance of jaundice, and that is when a patient has a complicating obstructive jaundice. This complication can very easily occur when gallstones are present, and in Mayo's[1] series of 100 cases they were present in 68% of the patients. Although the red blood cell fragility does not change after surgery, the patient is clinically well and there have never been any recurrences reported. Operative mortality is approximately 4%,—4 deaths in Mayo's[1] series of 100 cases, 2 deaths in Kanavel's[8] collected series of 48, and no initial mortality in a group of 18 children ranging from 2.5 to 14 years as reported by Kennedy[7].

A third condition which responds remarkably to splenectomy is Banti's disease. This condition was first described in 1883 and again in 1894 by Banti[8] of Florence—hence the name. Briefly, it consists of primary enlargement of the spleen, secondary anaemia with leukopenia, portal cirrhosis of the Laennec type and ascites. Neither the immediate nor the remote cause of the disease may be known, for when it is, the condition is not Banti's disease. W. J. Mayo[9] believes that von Jaksch's disease may be an early or infantile form of Banti's disease and therefore recommends splenectomy as a mode of treatment in many of these cases. Pathologically there is marked fibrosis of the Malpighian bodies as well as throughout the entire splenic pulp. When the liver has undergone cirrhotic changes, it also is characterized by a fibrosis around the portal and interlobular spaces with subsequent portal vein obstruction. Such obstruction of the portal vein associated with embarrassment of the splenic circulation produces the characteristic symptom complex of an advanced Banti's disease; namely, ascites, hematemesis, and visible signs of the establishment of a collateral circulation. The immediate surgical mortality as well as the prognosis depends entirely upon the time and stage of the disease at which surgical measures are instituted. Moynihan[8] gives the surgical mortality in early cases at 10% when operated upon during a favorable interval, whereas late or third stage cases carry a mortality of about 25%. In Mayo's[1] series of 148 cases the mortality was 9.4%, including early as well as late cases. It is of interest to note that approximately 10% of the patients in this latter series, who died during the 10-year interval following splenectomy, died from gastric hemorrhages[10].

In Gaucher's disease, splenectomy should be looked upon as a palliative procedure in that it apparently does not cure the condition but does increase the expectancy. It also adds greatly toward the patient's comfort and physical well-being, because in these cases the spleen often attains an enormous size. Bonta[11] reports 4 cases ranging in age from 26 to 36 years, who have had splenectomies and lived in comparative comfort for 7 months to 10 years. One of these patients died at the end of 2 years from

apoplexy. The surgical mortality at the Mayo Clinic[1] has been 28.5%, which is decidedly higher than in any other of the splenic anaemias responding to surgical treatment.

SUMMARY AND CONCLUSIONS

The anaemias, especially those which are most frequently encountered during adolescence, are closely related to splenic function. The treatment to be pursued in a given case of anaemia is so strictly dependent upon the type of anaemia that an accurate diagnosis is essential. Each type of anaemia has enough characteristic differential points that, with careful observation and laboratory study, a specific diagnosis can be made.

Splenectomy, when indicated and when preceded by proper pre-operative care, offers the best results with very low surgical mortality.

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Purpura Hemorrhagica*

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Purpura hemorrhagica is a disease of the blood-forming organs clinically manifesting itself by subcutaneous and submucous hemorrhages. In addition to the hemorrhage, there is (1) a markedly reduced platelet count; (2) a much prolonged bleeding time; (3) a non-retractile and less adherent blood clot.

Confirmatory symptoms, which may occur in other conditions are: (1) lowered resistance of capillary walls manifested by the tourniquet test (apply the cuff of a blood-pressure apparatus to the arm or leg and pump it up to a point midway between the systolic and diastolic pressures, when, if positive, a new crop of skin hemorrhages may appear in three minutes); (2) the usually enlarged spleen may be palpable; (3) age—primarily a disease of childhood; (4) sex—females affected twice as often as males; (5) it usually follows some acute infectious disease; (6) the anemia always present, in varying degree, is apparently always secondary to the hemorrhage.

The condition may run a very acute form, and unless heroic measures are employed, may terminate fatally in a short time. The chronic type is not uncommon; it does not develop from the acute form but is chronic throughout its course. These cases bruise easily, bleed intermittently, and terminate fatally or recover completely. It is neither congenital nor hereditary.

DIFFERENTIAL DIAGNOSIS

(a) The leukemias. (b) Pernicious anemia. (c) Aplastic anemia. (d) Diseases with enlargement of the spleen associated with purpura, slight or marked in its manifestations, such as splenic anemia or Banti's disease, hemolytic icterus, thrombosis of the splenic vein, Gaucher's disease, bone marrow tumors and osteosclerosis. (e) Infections

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such as subacute bacterial endocarditis, typhoid fever, acute tonsilitis with purpura, and other infections that cause a varying degree of inhibition of the function of the bone marrow. In such infections we may find not only anemia but purpuric manifestations. (f) Drugs and poisons: Benzol, benzine, and arsphenamine should be considered always as a cause, when purpuric manifestations occur. The frequent use of benzol as a solvent in industry must be borne in mind, particularly in the rubber and paint industries.

Chronic purpura may resemble hemophilia. In hemophilia there is lengthening of the coagulation time of the blood, but the clot, when formed, contracts; in purpura, the coagulation time is normal, but the clot does not contract. Also there is practically no reduction in platelets. In purpura hemorrhagica the platelets may disappear entirely, and they are always markedly reduced.

Purpura hemorrhagica may be hemorrhagic without being, necessarily, purpuric. Hemorrhages from the nose, stomach, uterus, or kidney may be the only complaint of the essential thrombocytopenic patient. And errors in diagnosis frequently occur, the condition being mistaken for a local disease. Cases having hemorrhages from the uterus have been curetted; hysterectomies have been performed, with resultant transfer of the hemorrhage from the endometrium to that of the operative lines.

Drs. Connor and Bumpus (Mayo Clinic) made a careful analysis of thirty-three unselected cases of essential hematuria and found evidence that in some cases the hematuria is a localized purpura hemorrhagica.

TREATMENT

(1) *Drug Therapy*, such as arsenic, calcium lactate, calcium chloride, ergot, adrenalin, foreign proteins, (horse serum, typhoid vaccine, milk, blood coagulants) and other internal medicaments have all been employed and have proven of little value, as have also local packings.

(2) *Blood transfusions* should first be employed. Duke has reported that the life of the blood platelet is much less than that of the red blood cell, the platelet living a few days, while Ashby has shown that the life of the red cell is from two to four weeks. This suggests that transfusion, to be effective, when platelets are reduced in number, must be repeated every few days. The normal platelet count ranges from one hundred fifty to four hundred thousand. In purpura hemorrhagica they may disappear entirely. They are supposed to be formed from particles of protoplasm which are pinched off from the large cells in the bone marrow. Their biological and chemical properties are not understood (MacLeod's Physiology) but for many years it has been known that they are intimately concerned in the coagulation of the blood and that spontaneous clotting cannot occur without platelets or their disintegration products.

Blood transfusion relieves the anemia—not its most important benefit, but it controls the bleeding by supplying enough platelets to permit natural hemostasis. Therefore the transfusions should be large. However, R. H. Potts, reporting a case in the New Orleans Medical and Surgical Journal, got better results by administering eight or ten c. c. of whole blood intramuscularly at frequent intervals and suggests that some activating agent or agents, not platelets, is formed from the disintegration of the blood clot at the point of injection.

Most authorities agree that whole blood is far superior to citrated blood in the treatment of this affliction. Beckman's Practice states that in citrate transfusions "large numbers of platelets stick to the gauze filter and to the glassware as can be easily proved by staining scrapings from the latter, and that citrate injections destroy platelets."

(3) *Ultra-violet rays*, combined with calcium, have given very good results in a growing series of reported cases. Heavy treatments are employed by some, even to the state of painful hyperemia. Seventeen years experience with this apparatus leads me to believe that better results will be obtained with smaller doses.

(4) *X-Ray and radium.* This form of therapy has little support even though Hoffman claims good results from the use of radium over the spleen. Unfortunately his

cases were not well checked with accurate laboratory findings.

(5) *Liver extract.* Only one case was found in the literature, but the results were so gratifying and liver feeding is proving such a valuable therapeutic agent that I feel it should be tried in these cases. Box and Massingham of London report an acute fulminating case in a child from whom they withheld blood transfusions and gave liver extract in quantity equivalent to a pound of liver tissue per day. This treatment was for a period of two weeks; the dose was then reduced one-half and given for a period of five days more. Within twelve hours there was an obvious amelioration of the hemorrhagic symptoms. The epistaxis slowly ceased, and after forty-eight hours there was no purpura. A few fresh purpuric spots appeared for one day and then no more. In six weeks time the child was apparently well. Their case complicated scarlet fever. They make the statement that "There is now plenty of evidence that the administration of liver extract causes a rapid and progressive increase in the number of platelets; indeed it appears to be the most efficient means in this direction which we possess, superior even, in its results, to blood transfusion." They also recommend its use in hemorrhagic small pox.

Last month Dr. F. S. Cook of Eau Claire employed the same dosage of liver extract in a severe case of purpura hemorrhagica, and, instead of such happy results, had a steadily diminishing platelet count. Large transfusions of whole, non-citrated blood were given; ultra-violet rays were employed, and still no improvement. He then referred the case to Drs. H. F. Derge and J. E. B. Ziegler of the Eau Claire Clinic, for a splenectomy. This was done, resulting in prompt recovery, and a platelet count of two hundred forty thousand at the expiration of forty-eight hours.

(6) *Splenectomy.* Unfortunately we know but little about the functions of the spleen. It is a store house for large numbers of red cells that can be delivered quickly into the blood stream as occasion demands—hemorrhage for example. It is intimately associated with the liver in digestive processes. It plays an important part in the defense reaction of the body. It quickly destroys defective red cells and defective platelets, but it is not a vital organ and at least a part of its duties can be taken over by other parts of the reticulo-endothelial system. Dr. W. J. Mayo says: "The spleen does not often act on its own initiative, but rather as an agent of destruction set in action by influences over which it has no control. In removing the spleen, therefore, one removes an agent of destruction not necessarily the cause of the disturbance."

That its removal promptly cures purpura hemorrhagica has been proven by a large and growing list of reported cases from all parts of the world. If less radical measures have failed, splenectomy should be performed with every reasonable expectation of success. The immediate improvement shown by stopping hemorrhages, phenomenal increase of platelets, disappearance of purpuric areas, and relief of symptoms is as gratifying and dramatic as anything we have to offer in the whole field of surgery.

The operative risk is little, in the chronic forms, but increases in direct proportion to the acuteness of the symptoms and the profundity of the toxemia causing the condition. Technically it may be classed among the more easily performed splenectomies. Seldom have adhesions been encountered. It is usually done in the first two decades of life, when the degenerative processes are not a factor in the make-up of the patient. The operation is comparatively simple and safe in the hands of experienced abdominal surgeons. Accessory spleens may cause failure in good post-operative recoveries, hence these should be looked for at the time of operation.

We should first attempt to tide them over the acute stage by less radical measures and then go about our task of removing the spleen.

Undoubtedly some apparently acute cases recover spontaneously and the attending physician or surgeon who has applied some remedy is inclined to give credit to his particular therapy.

Nowhere in the literature can I find a case where splenectomy has been performed,

which did not respond at once with a considerable rise in the platelet count; and if an operative fatality did not occur, the cure of the disease followed quickly and was permanent. The maximum count is reached in from ten to twenty days, falling to an approximately normal level soon after.

Dr. W. H. Evans says: "While there seems to be general agreement that the operation of splenectomy has a specific influence on blood platelet regulation, by virtue of the removal of a large part of the reticulo-endothelial tissue which normally acts as a destructor mechanism of diseased platelets, yet behavior of the platelet is influenced to some extent by other factors." Destruction of tissue and its subsequent absorption is undoubtedly a vital excitant of platelet production, as will be shown later. This last hypothesis explains how the subcutaneous injection of whole blood may influence the rise in the platelet count.

In this article Evans calls attention to the fact that the removal of the spleen is not the only operation causing an increase in platelets, but that it follows practically every surgical operation and every obstetrical delivery, natural or operative, and especially after caesarean section; that the more major the operation, the greater the platelet response. In the same publication is another article "Platelets and Thrombosis," in which Evans, collaborating with Dawborn and Easlam, proves by a large number of cases that the height of the platelet count is reached about the tenth post-operative day, a time coinciding with the usual time for the appearance of thrombosis (or milk leg) and embolic manifestations. They found that increased platelet production and stasis in circulation are the chief factors in the production of these two bugbears of the surgeon and obstetrician; and that, although sepsis might influence the time and height of the platelet rise, it may occur in its absence. This suggests that we lessen blood stasis by shortening the stay in bed of post-operative and obstetrical cases.

Stimulated by their report, I requested Dr. Garner Scullard, pathologist at Eau Claire, to make platelet counts on a series of consecutive cases as they occur in my surgical patients and in the obstetrical cases of Dr. E. P. Hayes, obstetrician of the Eau Claire Clinic. Our report is not completed, but so far the results have confirmed Dr. Evans' findings.

CASE REPORTS

I have covered the high spots in the acute case of Dr. Cook's which was splenectomized by two of my associates, and, for lack of time, I will briefly summarize two additional cases which I have attended.

Case No. I. Mrs. R., pregnant seven months, was admitted to the obstetrical service of Dr. E. P. Hayes at Sacred Heart Hospital, May 31, 1930. She was bleeding from every mucous surface: nose, mouth, rectum, vagina, and kidney. Every test enumerated above for purpura hemorrhagica was positive; the platelets practically absent; bleeding time twenty-five minutes; no retraction of blood clot at the end of eighteen hours.

Treatment: June 1, blood transfusion—400 c. c. whole blood, multiple syringes and Lindemann needle method, ultra-violet rays with calcium lactate, arsenic and iron internally.

June 5, second blood transfusion. Same method and dosage, quick response of platelets and cessation of all symptoms; discharged from hospital June seventeenth.

August 11, 1931, readmitted to hospital and delivered of a live baby girl. Both mother and child living and well today.

Case No. II. K. S., Polish boy, entered Sacred Heart Hospital, May 22, 1930, referred by Dr. Lundmark of Ladysmith for persistent nose bleed of three weeks duration, which responded to nothing in the way of local and systemic medication.

We gave him six blood transfusions from May 30 to June 30. He, too, presented all the symptoms of purpura hemorrhagica. No platelets on admission, only thirty thousand after the sixth transfusion, and nose still bleeding.

We removed his spleen June 30. His nose was bleeding when the operation was begun. It had ceased to bleed before the operation was completed and never recurred. Platelet count twelve days later was one hundred thirty-six thousand. Twenty days after the operation it was three hundred sixty thousand. He was discharged from the hospital July 25. The operation was uneventful and convalescence caused us no anxiety. He occupied a ward bed and required no more care than the average laparotomy patient. Platelet count in June of this year was two hundred forty thousand, and his general appearance was that of a normal boy.

Why the case of the pregnant woman, whose symptoms at the outset were the most serious, should respond to conservative measures, while the two other cases required splenectomies, we do not know.

But we *do* know that purpura hemorrhagica is an affection needing immediate diagnosis, the closest watching, together with prompt and effective therapy or a fatality is liable to result; and also that some cases are so acute and fulminating that death will result in spite of every known measure of relief.

SUMMARY

(1) Thrombocytopenia: A toxicosis increasing the permeability of capillary walls, resulting in hemorrhages from the mucous membranes and into the skin. It affects profoundly the bone marrow with resultant platelet deficiency and thereby causes slow clotting time and a non-retractile clot.

(2) Hemorrhages may be from a single organ and, as a consequence, the true condition be unrecognized.

(3) Prompt and heroic treatment in the acute cases needed to save life.

(4) Treatment: hospitalization; blood examination; internal medication; blood transfusions of whole, non-citrated blood, often repeated; intravenous or subcutaneous transfusions; ultra-violet radiation; radium over spleen; liver extract; splenectomy, which is followed by rapid rise in platelet count and relief of symptoms, mortality low.

Platelet rise follows all surgical procedures and obstetrical deliveries, and is a large factor in the production of thrombi and emboli.

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The Inefficacy of Present Day Treatment of Pernicious Anemia

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When we compare the treatment of pernicious anemia of to-day with that prior to August, 1926, we must admit that it is very effective. The treatment prior to liver therapy consisted chiefly of giving tonics and blood transfusions. Every physician realized that the measures he was employing were only temporary and that sooner or later the malady would be fatal. The vital statistics for Nebraska show that there were 121 deaths from this disease in 1926, 76 in 1927 and 63 in 1928, a decrease of almost 50 per cent. However, when we observe the pathetic picture of cord degeneration in our patients with pernicious anemia, which keeps on progressing in spite of all treatment, we must admit that present day treatment is still very ineffective. Formerly, the anemia often proved to be the "coup de grace" to these unfortunate people. Now a large percentage develop a psychosis, suffer a long period of helpless and hopeless invalidism, with agonizing lumbar pain, a cord bladder, loss of rectal control or a paraplegia. The interval of five years is still too short to determine whether the ultimate fatal outcome has been prevented or merely delayed.

There are various factors influencing the inefficacy of our present day treatment. The etiology of the disease is still unknown. The treatment must therefore be purely empirical and symptomatic. Recent work has disclosed the nature of the substance in liver which is active in pernicious anemia.[1] The work of Castle[2] and his associates indicates that "pernicious anemia is a deficiency disease resulting not from a direct inadequacy of the diet, but a conditioned deficiency, produced by the failure of some function of the normal stomach to take place in the stomach of the patient with pernicious anemia." Moschiowitz[3] considers the disease partly the

result of a deficiency and partly of a defective gastric hormone of which achlorhydria is the most tangible symptom. The warning of Carey[4] not to be too dogmatic in formulating an etiological hypothesis from the effects of present methods of therapy is very opportune.

More cases of pernicious anemia are now being seen, diagnosed and treated than ever before. The blood picture has been considered as a standard for the clinical diagnosis and as an indicator of response to treatment of this disease. A color index of plus 1, a decreased red count, macrocytes, anisocytosis, poikilocytosis, polychromatophilia, and leucopenia have been considered characteristic of this disease. Now we find that the blood picture of pernicious anemia is often simulated by various forms of aplastic and hemolytic anemias. The exact blood picture should be considered more as an index of the severity of the anemia and the nature of the bone marrow activity, whether hyperactive, sluggish or aplastic, than the particular form of anemia. The laboratory data should only be considered as an aid in making the clinical diagnosis and never the basis of making the diagnosis. As an indicator of response to treatment, the blood picture does seem to be of considerable value. The aphorism that "the anemia which does not respond to liver therapy is not pernicious anemia" does seem to be true.

The symptoms and signs referable to the digestive and neuro-muscular system are of at least equal diagnostic importance to those of the hematopoietic. The achlorhydria is always present. In one of Middleton's[5] cases, the achlorhydria preceded the development of the clinical picture by fourteen years. In another the neurological symptoms preceded the blood picture by four years. There, apparently,[6] is no definite relationship between the extent of cord degeneration and the degree of anemia. The presence of typical cord changes and achlorhydria are sufficient to warrant the diagnosis of pre-anemic pernicious anemia.

It is difficult to determine accurately the exact incidence of this disease. It would appear larger than generally thought. My records show that there were thirteen cases in my practice in a period of fourteen months. All of these patients resided in an area with a radius of twenty miles, and with a total population of 10,000. All of these were between the ages of 35 and 65 years. Undoubtedly, some of my fellow practitioners here also found several cases. An incidence of one case per thousand population would seem to be a conservative estimate for this locality.

FACTORS IN TREATMENT

The most important factor in making our treatment so ineffective is the fact that our remedies are specific only for the hematopoietic phase of this disease. In my series of cases I have used whole liver, liver extract No. 343, ventriculin, and combinations of these. In each case the red blood count reached 4,500,000 within a period of three to five months. Some cases seemed to respond more readily to ventriculin and others to liver therapy. The effect of this treatment on the gastric and especially on the nervous symptoms has been very disappointing. In only two instances have the patients regained health to such an extent that they can enjoy life and perform their usual daily work.

Very likely, a factor in our present unfavorable results is that our patients discontinue the use of liver or ventriculin when their blood count approaches normal and they are feeling better. Under present economic conditions many patients find it impossible to maintain continuous treatment because of the cost of the material.

The efficacy of our present treatment could be greatly increased if many of these cases would be diagnosed while still in the pre-anemic stage and treatment then instituted. Many of our present cases with vague stomach symptoms, which are definitely not due to ulcer or biliary tract disease, may in a few years prove to be pernicious anemia. Similarly, many cases now considered neurasthenia may later develop definite cord symptoms. We should no longer lay so much emphasis on the blood picture[6] since "no single feature of it is pathognomonic for pernicious anemia." The emphasis should be placed on the neurological signs and the achlorhyd-

ria. The general practitioner is able to test for achlorhydria in less time and with less equipment than to do a blood count and examine a blood smear. The data obtained is far more indicative of the disease. Likewise every physician can examine his patient for the spinal cord manifestations found in this disease. These patients[7] complain of a generalized weakness, a numbing and tingling, a feeling which, they generally state, cannot be described accurately but which they designate as, "I just seem to go all to pieces." They show signs of hyperactive deep reflexes, ankle and knee clonus, impaired or lost vibration and position sense, Babinski sign, hypo- or hypertonia and ataxia. Very frequently the signs are almost identical to those of tabes. However, the pupillary signs common in lues are absent in pernicious anemia.

Insuring that our patients obtain adequate amounts of liver, liver extract, or ventriculin and this begun in the early stages of the disease, will at present give by far the best therapeutic results. Starr[8] has shown that maintaining the blood count at 5,000,000 per c. m. tends to prevent spinal cord degeneration. Liver and ventriculin have been found specific for this. Degenerative changes in the spinal cord are permanent and frequently progressive. It is therefore imperative that an early diagnosis be made and adequate treatment instituted and continued.

It seems as though it would be a good business to make a survey of the cost of production and of the most effective method of administration, whether oral, intramuscular or intravenous. Some arrangement should then be made so that these patients will receive and maintain an adequate amount of liver or ventriculin.

SUMMARY

1. Liver, liver extract and ventriculin are specific for the hematopoietic phase of pernicious anemia.

2. Present poor results are due to the inefficacy in treating the digestive and neuromuscular phase.

3. Results can be improved by insuring adequate amounts of liver, liver extract or ventriculin to patients with pernicious anemia.

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Cardiac Irregularities*

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The object of this paper is to discuss the clinical significance of irregularity in rate and rhythm of the heart beat in recognizing early myocardial disease. Few people realize that heart disease is a more serious public health problem at the present time than either tuberculosis or cancer insofar as actual numbers can measure the destruction of human life. The public is inclined to consider heart disease as a more or less chronic ailment, not preventable and naturally they

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assume there is nothing that the individual or the public can do to prevent it. This, of course, is not true.

A certain per cent of heart disease is preventable and quite a large number of cases are curable if the affliction is discovered early and the patient kept under proper medical supervision. Deaths from heart disease can often be prevented and certainly postponed many years. Deaths from heart disease in Wisconsin in 1908 were 96 per 100,000 population. The rate for 1928 was about 200. This shows that the death rate of heart disease increased over 100 per cent during the 21 years and the rate is still going up.[1] Heart disease is today the greatest single cause of death.

The classification of heart disease from the etiological standpoint includes: 1. A group to which no known etiological factor can be attributed, 2. Rheumatic fever with its clinical picture of polyarthritis, chorea, joint pains, tonsilitis, pharyngitis, erythema nodosum, etc., 3. Syphilis, 4. Bacterial infection, under which you can classify subacute infectious endocarditis, 5. Thyroid disease, 6. Toxins, referring particularly to the toxins of diphtheria, tobacco and coffee, 7. Neurocirculatory asthenia, 8. General systemic disease; such as, arteriosclerosis, chronic nephritis, diabetes, emphysema, hypertension, anemia and, lastly, congenital developmental defects.

ETIOLOGICAL FACTORS

I would like to discuss some of these etiological factors: rheumatic fever, syphilis, acute infections, thyroid disease and toxins. They all produce an acute or a chronic myocarditis which may vary greatly in degree. I will not discuss the acute myocarditis which is rapidly progressive and goes on to heart failure and death. I wish to take up chiefly those forms which develop into a chronic myocarditis and those forms of chronic myocarditis which in themselves may have effect later on in life.

The onset of the acute myocarditis can rarely be determined with accuracy because the condition usually develops during or immediately after an acute infection. There are no characteristic symptoms. The condition is to be suspected if circulatory disturbances appear during or following an acute infection. Even under such circumstances diagnosis can seldom be made with certainty as the symptoms of myocarditis may not develop for several weeks after subsidence of the acute stage of the infection.

Acute myocarditis often causes anxiety and a sense of oppression or pain in the chest, especially in the precordial region. The heart action is usually disturbed, the rate is rapid and any of the forms of irregularity may appear. Brachycardia is an occasional manifestation. The pulse is soft, small, easily compressible and reflects the irregularity of the heart. The blood pressure is diminished, the heart enlarged. Heart failure may set in or the disease may assume the chronic form. Acute myocarditis is more common in childhood and early adult life and is comparatively rare in individuals over forty. The frequency with which it occurs cannot be stated because it often runs its course without producing any symptoms which make diagnosis possible. The diagnosis is often made when no myocardial lesions are found at autopsy. This incidence is in sharp contrast with that of chronic myocardial disease, wherein three-quarters of the cases are found in that period of life between 41 and 70 years. These figures are for conditions without structural lesions of the valves.

Rheumatic myocarditis occurs to some extent in probably not less than 90 per cent of all patients with acute rheumatism. The myocardial changes, however, in the majority of cases are slight and often transitory or heal without leaving clinical evidence of having existed. Such slight involvements usually pass unrecognized unless special search is made. In the more pronounced cases the usual signs and symptoms are those above described. Impulse conduction is frequently delayed. Premature contractions are very common and more serious arhythmias, such as, auricular fibrillation occasionally develop. Tachycardia is the rule, although brachycardia may be encountered as a rare and usually grave symptom. Rheumatic endocarditis and pericarditis very frequently accompany myocarditis and render

its diagnosis extremely difficult in many cases.

Diphtheria is complicated with myocarditis fairly often, especially when the use of antitoxin has not been adequate or early. This form of myocarditis may be slight and cause few symptoms, but when diphtheria is neglected it is likely to be very severe and often fatal. Even in patients with few or no recognizable cardiac symptoms the heart may be so extensively damaged that moderate exertion may cause collapse or sudden death.

I believe we can be much more cautious in our attempts to properly evaluate the condition of the heart following all the acute infections, especially in younger individuals. Any alterations in the rhythm, any tachycardia persisting beyond the normal clinical course of disease should be viewed with grave suspicion. Any feeble rapid pulse, tendency to low blood pressure, excessive weakness, exhaustion, restlessness or any anxiety following the infections should cause us to be especially suspicious of the heart. Dilatation following an acute infection should make us be convinced of the presence of a myocarditis. The condition may get more severe or may go on to the chronic stage or may heal entirely.

I am, personally, very suspicious of a so-called "healed acute myocarditis", as I feel that the disease has produced a definite permanent effect on the heart muscle. The patient should be kept at complete rest in bed and should be forbidden to make any unnecessary effort which would throw added strain on the heart. This should be continued until all evidences of active infection have disappeared. When the infection has been severe or of prolonged duration, rest in bed should continue well into convalescence. In acute rheumatic fever the patient should not be allowed to sit up in bed until the temperature has remained normal and the pulse returned to normal for at least two weeks, and when cardiac symptoms have been present this period should be much lengthened. In the early stages the subject should not even feed himself and must not sit up in bed. All forms of mental excitement must be avoided and abundant sleep secured by the use of bromides and simple sedatives.

Chronic myocarditis accompanies practically all of the forms of heart disease which we see in the latter half of life. Taken in the order of their frequency of occurrence, we have: hypertension heart disease, coronary sclerosis, rheumatic heart disease, luetic heart disease, hyperthyroid heart disease, and, lastly, right heart failure due to intra-pulmonic disease. Gross examination of the heart reveals hypertrophy and dilatation and in some instances evidence of an increase of the quantity of the fibrous tissues. Microscopically there is round cell infiltration in the interstitial tissues and parenchymatous degeneration of the muscle fibers in areas where the process is active.

Syphilis is the only chronic specific infection which is a common cause of myocarditis. It is a rule that the occurrence of an uncomplicated aortic insufficiency in a man of about forty years of age is usually syphilitic. The maintenance of a persistently negative blood Wassermann in cases of syphilis is not consistent proof of the cure of the disease, as syphilitic carditis has occurred in cases with negative blood Wassermanns but with a Wassermann positive in the spinal fluid. Our anti-syphilitic therapy should always include the investigation of the spinal fluid.

Chronic myocarditis may develop as a late stage of the acute process or may occur without previous evidence of the acute form. The most common acute infections which cause it are acute rheumatic fever, typhoid fever, influenza, the septicemias and occasionally diphtheria. Chronic myocarditis in some degree is almost always associated with various forms of chronic or subacute endocarditis and is often the most important cause of heart failure in such patients.

In the majority of cases of chronic myocardial diseases the lesions are degenerative in character. The most common causes of myocardial degeneration are chronic vascular diseases such as general arteriosclerosis, sclerosis of the coronaries and aorta, syphilitic endarteritis and chronic hypertension. All of which interfere with the nutrition of the heart muscle. Chronic focal infection in

the teeth, tonsils, sinuses, gall bladder or elsewhere may occasionally be a cause. It is difficult and often impossible, however, to establish any relation between chronic myocarditis and such disturbances.

I have in mind a case of auricular fibrillation which resisted treatment in which we were not able to establish a definite causative agent. X-ray of the teeth was negative. Later a tooth was pulled solely on the basis of discomfort and was found to have a granuloma at the root. The fibrillation promptly ceased.

Chronic myocardial disease due to hypertension causes fairly characteristic pathological changes. There is marked hypertrophy of both ventricles with extensive dilatation. Some of the largest hearts found are the results of prolonged hypertension. The auricles are much less affected than the ventricles. They are usually greatly dilated, however, and at time undergo considerable hypertrophy. The condition known as essential hypertension associated with chronic interstitial nephritis are the two great causes of this type of myocardial degeneration and are regarded by some as the most common causes of chronic myocardial disease in general. The left side of the heart is predominately affected.

Chronic myocardial disease may produce no symptoms whatever and may even be the cause of sudden death of the apparently healthy individual. Careful examination will in most cases, however, reveal abnormalities which are sufficient to establish the probable diagnosis. Close questioning also brings to light symptoms which suggest the existence of some impairment of cardiac sufficiency of which the patient is unaware; such as, moderate shortness of breath following stair climbing, walking against a high wind, running a short distance. There is almost always an associated dilatation and hypertrophy of the heart. This should be found in the course of a routine examination and should arouse suspicion of chronic disease of the heart muscle. Occasionally fibrillation of the auricles may be unnoticed by the patient or pulsus alternans may be discovered during auscultatory determination of the blood pressure. Congestive cardiac failure is much the more frequent form and has been estimated to occur in not less than 70 per cent of cases. The most common initial symptom is breathlessness following exertion, slight puffiness above the shoe-tops at night which disappears in the morning, slight coughing often accompanies the breathlessness and it sometimes is wrongly attributed to a cold. It is in reality due to a slight passive congestion of the lungs. The symptoms of advanced congestive failure need not be entered into here. The heart rate is commonly increased even during rest. Disturbances of rhythm are frequent, the auricles fibrillate in more than 50% of the patients. This may be transitory or paroxysmal but is generally permanent. Many of the ventricular beats are too feeble to transmit a wave to the wrist so that the radial pulse rate is usually less than that of the heart. This difference is called the pulse deficit, and to a certain degree is usually more or less parallel to the degree of cardiac failure.[2]

The relationship of thyrotoxicosis to myocarditis is very interesting. It is being emphasized more and more that thyrotoxicosis, as such, has no destructive action on the heart musculature which can be distinguished either microscopically or by interpretation of clinical findings, except that which is due to continuous mechanical strain. In other words, the excessive rate and drive to which the heart is subjected. Lahey[4] has recently stated that patients without previously existing heart damage, relieved of their intoxication by adequate thyroidectomy, subsequently exhibit no permanent damaging effect in the heart. Cardiac decompensation associated with hyperthyroidism is due to the effect of the hyperthyroidism upon a previously damaged heart rather than the damaging effect of hyperthyroidism upon the heart. The relative infrequency with which cardiac complications occur in young people and their frequent appearance in patients in late middle and later years of life when sufficient time has elapsed to develop cardiac damage, lends weight to the probability of this assumption. Hamilton[5] states that in thyro-cardiacs systolic murmurs are not heard except in those cases in

which a pre-existing heart damage is present. Auricular fibrillation is the most frequent cardiac abnormality. The older the patient the greater the possibility of fibrillation. Similarly coincident or pre-existing cardiac damage predisposes to this phenomenon[3].

Richter[6] has stated "cardiac decompensation and fibrillation may cause some delay in the preparation for operation. I recognize their seriousness but I insist that fibrillation particularly must not be considered a contraindication for surgery[3]." I think we must be particularly careful in planning the treatment for a mild case of thyrotoxicosis to inquire carefully into the past history of infections, to examine particularly carefully for evidences of pre-existing cardiac disease, as we know that thyrotoxicosis kept up over a long period of time in a patient with a previously diseased myocardium, may result in the precipitation of an early myocardial failure.

Under the classification of neurosis we see patients who present one or more of the following symptoms or signs: breathlessness on exertion, heat exhaustion, precordial pain, palpitation, giddiness, faintness, tachycardia, sinus arhythmia, diffuse cardiac impulse, sluggish peripheral circulation, accidental murmurs, unstable blood pressure. This group of symptoms and signs has been variously termed effort syndrome, neuro-circulatory asthenia and irritable heart. This etiology is probably not concerned in the production of true heart disease but it is mentioned because it produces symptoms like those found in true heart disease and may occur coincidentally with a previously existing damaged myocardium[7]. Our therapy in this type of case is guided in a great measure by the history of a possible previous cardiac effect.

SUMMARY

The symptoms: fast heart, palpitation and those attributed to irregular heart beat are frequently encountered while taking histories. I believe that sufficient clinical importance must be attached to these symptoms and that the physician should feel called upon to go into the past history of the patient and determine the possibility of a pre-existing cardiac disease. Will not those patients on whom you make a diagnosis of hypertension, arteriosclerosis, coronary sclerosis, luetic heart disease, hyperthyroidism, diabetes, require a much more rigid treatment, if in the course of the history we are able to determine the possibility of early adult myocardial disease? Joslin has repeatedly stated that in his belief high-fat diet predisposes to the early development of arteriosclerosis. If this is the case will not our diabetic therapy be modified by the knowledge that myocarditis exists in a given patient? I am convinced that we as physicians must be extremely watchful over our patients recovering from the acute infectious diseases. I refer particularly to those patients in the first and second decades of life. The occurrence of irregularity in the heart rhythm, of tachycardia out of proportion to the clinical picture, of slight myocardial dilatation, should put us at once on our guard that this patient may be suffering his first myocardial damage and, I believe, that we should over-treat rather than under-treat. Rest is our greatest therapeutic agent and the least we can do is to give these patients several weeks more rest than is possibly necessary rather than give them too little rest and too little opportunity for the heart muscle to recover.

I am sure that greater watchfulness at this period of life over patients recovering from the acute infections will have a definite effect on the cardiac mortality later on in life. Many patients above 50 years of age come to us complaining of cardiac irregularity or possibly fast heart or excessively slow heart beat. These patients should have a careful history taken, especially to determine the habits of eating, the habits of sleeping, the consumption of coffee, and tobacco. It is not an unfair request of a patient to give up tobacco and coffee for two or four months and watch the effect. They themselves will be the judge as to whether to continue their abstinence. Habits of over-eating and under-sleeping which are one of the great American faults combined with our high-tension manner of living can be very easily regulated and with the co-operation of the

patient may produce a great increase of longevity.

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History in the Diagnosis of Pulmonary Tuberculosis*

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Almost fifty years ago, Dr. Edward Livingston Trudeau established the first sanatorium in this country for the scientific treatment of those suffering from pulmonary tuberculosis. In that little cottage with a veranda hardly large enough for two chairs, the first patients were treated along suggestions laid down by Brehmer, modified by Dettweiler, and personally experienced by "The Beloved Physician" himself.

Since that time, much progress has been made. Years of experience, intensive study and diagnostic refinements have made it possible for us to recognize the case of pulmonary tuberculosis long before irreparable damage has been done to the body; heliotherapy and the various forms of surgical relaxation and collapse of the lungs have saved the lives of many patients. The progress of sanatorium construction and equipment is well exemplified by a comparison of "The Little Red", still standing at Trudeau, with that of one of the most modern and most completely equipped institutions a short distance away. Paradoxically, the sanatorium of today is no longer a sanatorium; it is a well equipped hospital in every sense of the word. From this first beginning in the Adirondacks has grown a vast network of institutions throughout the entire country, so that today long distances from home are no longer necessary to obtain the best type of treatment.

And yet, in spite of all this progress in diagnosis, in therapy and in equipment, when all is said and done, when we scan the list of patients who have entered the sanatorium during the past ten years and compare it with a report of the condition of those patients today, I am quite certain that we all feel that there is still much to be desired; that the final results obtained are far, far from satisfactory.

The large number of patients classified upon admission as moderately and far advanced is still the "bete noir" of all sanatorium physicians, and must be given the ranking position among the reasons and causes for this failure to reach our ideals. When 70% to 80% of patients present themselves for treatment at a time when the best opportunity for recovery has passed, it is perhaps not surprising that our results are somewhat disappointing.

In an attempt to find a possible cause for our high percentage of advanced admissions, we have carefully questioned a large group of patients, and have come to the conclusion that the most common reasons for the delay in seeking sanatorium care may be included under the following causes.

(1) Patients do not seek medical advice in time.

(2) Physicians delay in making a diagnosis of tuberculosis.

(3) Patient's refusal to follow the advice to go to a sanatorium.

The first and third causes are not pertinent to this discussion. The second is. Why is it that patients so frequently have to wait months before a diagnosis of tuberculosis is made? And why is it that so many patients

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consult two or three, sometimes five and six physicians, before their symptoms are properly interpreted? Is the diagnosis of pulmonary tuberculosis so difficult? At times, yes. Again, a positive diagnosis may be impossible. But certainly the majority of cases do not fall into these very difficult or impossible groups. Allen Krause believes that 80% of cases can and should be diagnosed by the man in general practice and who is usually the first to see the patient. In a paper published several months ago, John B. Hawes, II, came to the conclusion that of the patients who consulted him while in the advanced stages of this disease, the cause for the delay was about equally divided between physician and patient.

DIAGNOSIS

For a practical working basis, the diagnosis of pulmonary tuberculosis may be divided, like Gaul, into three parts.

(1) History and symptoms.

(2) Physical examinations.

(3) Laboratory aids—including tuberculin test, sputum examinations, blood examination, temperature record, stereoscopic x-rays of chest, etc.

It may be conceded that today none of us would be willing, and no one should be expected to make a diagnosis of so serious a disease, without the use of all possible means at our command. Yet, if limited to the use of but one of these methods, which one alone would give us the best results? I am quite confident that most of you will agree with the statement that earlier diagnoses, more frequent diagnoses and more correct diagnoses can be made from a careful history alone, than from a physical examination alone or the laboratory alone.

Inability to properly elicit and interpret physical signs, neglect to make repeated sputum examinations, temerity in requesting x-ray films, undoubtedly are the cause of many missed diagnoses, but the failure to take a careful history is, I believe, more frequently responsible than any other one cause. Not only does the history give us those most valuable clues as to the possible presence of lung pathology, but in the aeroplane view of the patient's past and present, presented by a detailed history, we can at times visualize more clearly the picture of early tuberculosis than we can through the bell of the stethoscope, the microscope lens or the stereoscopic mirror. And it is especially in the early case, when physical signs are vague and indefinite, when sputum is either absent or repeatedly negative, and even when those soft, cottony densities on the x-ray film are not entirely convincing, that the searching history will prove of greatest value and aid us in coming to a definite decision.

Years ago, we were taught that in order to make an early diagnosis of pulmonary tuberculosis the consistent and persistent examination of the sputum was absolutely essential. The well-known aphorism of Lawrason Brown, namely, "that failure to ask for and examine the sputum repeatedly in any patient with chronic cough is inexcusable" still holds today, but unfortunately when the laboratory report tells us acid-fast bacilli are present we know that we are no longer dealing with an early case. We also know that if sanatorium treatment is to be the success that all of us desire and hope for, the modern medical and surgical measures must be given the proper opportunities to show their real value.

The ratio of early sanatorium admissions must be decidedly increased. We must teach our students, both undergraduate and postgraduate, that if they would diagnose pulmonary tuberculosis in its clinical incipiency and thereby live up to the responsibility and confidence of their patients, a carefully taken history is an absolute "sine qua non". In the same article mentioned above, Hawes, II, reviewed 379 of his private cases to determine upon what factors his diagnosis of tuberculosis was made. He reports that his diagnosis was based—

On history and symptoms in 60% of his cases,

On physical examination in 20% of his cases,

On hemorrhage in 13%, and

On x-ray findings in 7%.

Since the presence of hemorrhage is essentially a part of history, Hawes actually based

his diagnosis on history and symptoms in 73% of his cases.

Stewart, in his very excellent pamphlet on "History Writing", says: "A carefully taken, searching, complete history carries us farther toward an understanding of the case than almost any other means of investigation, and at least half makes both diagnosis and prognosis."

VALUE OF HISTORY

The history to be of real value must be a complete one; careful attention to details and intelligent questioning will frequently bring to light facts considered irrelevant by the patient.

To find family contacts is exceedingly important, because these contacts are apt to be especially early and intimate. On the other hand, occupational or social contacts, as that of a nurse or a mechanic working on the same bench with a careless cougher, a former roommate or close friend, are all too commonly the cause of the continued massive infection.

And then the history of previous diseases! What wealth of information, when carefully interpreted, is all too often hidden in the rather fragmentary and indefinite story of the patient! Those "frequent hard colds", the "nervous breakdown" while at school, the "recurrent attacks of flu", the "prolonged convalescence after pneumonia"! These, when carefully studied and properly correlated, may give us a picture developed by the proper placing of the pieces of the picture puzzle of our childhood. For me to remind you that pleurisy with effusion coming on without definite cause, is in the majority of cases but an early manifestation of the activity of the tubercle bacillus, or that the coughing up of a teaspoonful of blood or more should be considered as tuberculous in origin until proven otherwise, is like carrying coals to Newcastle. I would, however, call your attention to these recurring attacks of relatively mild and so-called dry pleurisies; while no doubt many of these may be of a benign character, when recurrent in nature and coming on without a clear cause, I invariably have the premonition that perhaps some previously dormant tubercle bacilli have been disturbed in their slumber. To locate the cause of a spontaneous pneumothorax, in an apparently healthy individual, is at times a difficult task, but if we are to bear in mind the best interests of our patient, it is well to consider early tuberculosis as a probable guilty party.

The account of the present illness should be taken in chronological order and then amplified and clarified by pertinent questioning. Active tuberculosis, with few exceptions, manifests itself by the presence of symptoms of toxemia, and if any of these are present, tuberculosis must be given careful consideration. With this train of symptoms, so familiar to all of us, in mind, a diagnosis can very frequently be made from the clinical history alone. Localization of the lesion by physical examination and stereoscopic x-ray films, and possible confirmation of the etiological factor by sputum examinations, complete the diagnostic picture.

While this whole procedure seems and is relatively simple to those of us who are constantly dealing with tuberculosis, we must remember that the large group of physicians, who as a rule are the first to see the patient, are not as tuberculosis-minded as we are.

SUMMARY

To arouse in the mind of the physician the suspicion of a possible tuberculous involvement in the patient complaining of chest pathology, is the main purpose of this discussion. If once tuberculosis is suspected, more thorough examinations will follow and more early cases will be diagnosed.

CRETINISM IN WISCONSIN

In preparing a paper on "Cretinism in Wisconsin" to be read at the annual meeting of the society in September, it occurs to me that in addition to the twenty cases I now have to report that there must be many more in various parts of the state which have thus far been unreported.

This question is an important one, for apparently in the last decade many new cases have come to light, and the writer would be very grateful for a record of as many as possible.

A personal communication, giving ages, mental condition, physical characteristics, etc., will be appreciated.

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THE JOURNAL CLINIC

Immunotransfusion; With Case Report

By H. C. U. MIDELFART, M. D.
Eau Claire

The term immunotransfusion dates back to 1919, when Almroth E. Wright published his first case of serum therapy, combined with blood transfusion. He reported a case of sepsis that seemed to be beyond help,—but that recovered after transfusion with blood mixed with a measured amount of staphylococcic vaccine immediately after the bloodletting. It appeared to him that this had been of decided benefit and he suggested the name.

The degree of immunity produced was tested by intracutaneous reaction, after the donor had gotten vaccine in different ways—subcutaneously, intramuscularly and intravenously—but there seemed to have been little system in the method and there were very few imitations following this experiment. If the autovaccine could not be obtained, a standard staphylococcic vaccine was used.

In 1925, Levy Wiseman published a case of autogen sepsis, following influenza, with recovery. His patients first got two ordinary transfusions, without any results, and following this he gave four immunotransfusions from a donor that received an intramuscular vaccine injection four hours before bloodletting.

Bussello, in 1927, published several cases with patients receiving intramuscular blood injections from donors who had been treated with vaccine. Three years later he changed his technique and published better results with immunotransfusion—even in desperate cases.

In 1928, Oudard Guichard and Le Bourgo published five cases, four of which were streptococcic sepsis, and he followed, in principle, the Wright's technique. One of the cases died and four recovered. They found that the bactericidal effect of the blood of the donor increased for the first six hours, gradually—then became stationary for forty-eight hours, and, after that, gradually diminished.

Hebert, in 1928, reported a case of streptococcus viridans that recovered after immunotransfusion. The donor was treated eight times with subcutaneous injections and two hundred c. c. of blood was taken twelve hours after each vaccination. The case recovered.

In 1928, four cases were reported by Maunsaki—in one of them, four transfusions for autogen sepsis, with recovery. Maunsaki recommends polyvalent vaccine if autovaccine is not to be had. The question comes up whether immunotransfusion should be used in preference to simple blood transfusion. The experience with simple transfusions, in septic cases, is sufficient to form an opinion about simple transfusion—and most surgeons agree that the result is almost nil in severe septic cases. Reports of several cases, first treated with repeated transfusions without any results, and afterward treated with immunotransfusion, with recovery, points in this same direction.

Moritch and Hoche, from Eiselburg's Clinic, in Vienna, emphasize the importance of the donor and the recipient belonging to the same group—finding that the capacity for agglutination of the patient's blood has increased if in the same group. But if the donor and recipient belong to different groups, a diminution of antibodies takes place and they use this as an explanation for the difference in the results of immunotransfusions in septic cases that they have observed.

CASE REPORT

What I here have reported is mostly an extract from Doctor Knut Halberg, of the University Clinic of Upsala, who reports four cases of sepsis, from the years of 1930 and 1931, where immunotransfusions have been used. However, before I give a short

resume of his four cases, I shall take the liberty to cite my one case which gave the occasion for this report.

Miss A, female, white, 39 years old, stenographer. She entered the hospital on February 27, 1932, with the following history: Patient dates the onset of her present illness to February, 1931, when she had an attack of influenza, with a high fever, abdominal cramps and diarrhoea. This confined her to bed for a few days, after which she tried to go back to work; but the next day became so ill that she was confined to bed for two weeks, with fever, sweats, muscular weakness, soreness and diarrhoea. Her convalescence was slow and she felt weak and rather tired for several weeks and did not fully recover. In April she became ill with what was diagnosed as rheumatic fever. Her large joints became swollen, red and tender and became involved one at a time. She had a low grade fever, with marked perspiration. She did not stay in bed, but went to work on crutches and sometimes with a cane. This condition lasted approximately three months, or until the latter part of July. Then the swelling and tenderness of the joints disappeared. In August, the patient began to get severe chills, which would last one-half hour and be followed by fever for an hour, leaving her weak, tired and listless. She had daily chills every afternoon and evening for nearly two months. During this time she had no appetite and lost seventy pounds in weight. Her weight, before she was taken sick, was 205 pounds. During November, 1931, the chills became less severe and not so frequent—2–3 times per week. Patient felt weak and tired and suffered with heart palpitation. On November 8, 1931, she had to quit her work. In December, patient contracted a rather severe cold; later pain on inspiration on the left side. A diagnosis of pleurisy was made. The chest was tapped and the pain disappeared in ten days. Since that time patient has had severe chills and fever, as before, approximately once every two weeks—and otherwise 2–3 minor chills per week. She has been weak and tired; has had rheumatic pains for the past weeks, not severe, and skipping from one joint to the other, with no redness, swelling nor tenderness. There is nothing of importance in the family history or in the previous history of the patient, for the present condition. Of the physical findings, I shall just mention that she was fairly well nourished; weight 130 pounds; large framed and very tall; previous weight being 205 to 210 pounds. She looked very tired and anemic and, as previously stated, complained about shifting rheumatoid pains. Her skin felt rather cold and clammy and there were a number of small petechial points scattered over her body, which she said had been going and coming for a long while. There was great muscular weakness. Her lips were parched. Pulse was arhythmic at times, with skipping of beats. She felt dyspneic at times. Pulse was 114 per minute. The apex beat was in the fourth interspace, outside of M. C. L.—slightly enlarged heart dullness to the left—auscultatory:—a distinct diastolic blow over apex transmitted into the axilla and also faintly over the sternum. Blood pressure 118/76. Abdomen: — obese, pendulous, soft — liver palpable three fingers below costal margin—edge of spleen palpable and some tenderness over splenic area. Pelvis negative. No swelling, tenderness, or limitation of motion of the joints—no swelling of the legs. Urine contained a faint trace of albumin. Temperature was slightly elevated, but did not often go above 100.

This history of infection, with chills and fever, gradual loss of flesh, great weakness, petechiae, muscular pains, joint pains, the murmur at the heart, and, as I had occasion to see a couple of times during her stay in the hospital, localized swelling and tenderness in the muscles, made me consider the possibility of a subacute bacterial endocarditis. Blood, for a blood culture, was taken and the report (February 29, 1932) stated "short chain streptococci after forty-eight hours incubation".—Doctor Scullard, pathologist. A blood count was also taken on February 27th and showed red blood cells 3,580,000 with a hemoglobin of 60 and a white blood count of 14,150. The patient seemed to have considerable resistance against an infection that she evidently carried. Thinking that if we possibly could increase this resistance, she would be able to overcome her trouble, my thoughts turned to immunotransfusion as worth while trying. Luckily we got a donor, belonging in the same group, in her sister. Her brother-in-law did not belong in the same group, but we thought we would try to treat both of them with vaccine, thinking we could use possibly the serum from the brother-in-law and the whole blood from her sister and thinking that we possibly would have to repeat the transfusions. The technique for giving the vaccine, so as to be able to produce the most immunity, was rather vague to us. The sister and the brother-in-law were repeatedly injected with increasing doses of a measured amount of vaccine. This took about ten days. Twenty-four hours after the last vaccine injections, blood was drawn from both the sister and the brother-in-law and about 250 c.c. of the sister's blood was immediately put into the vein of the patient. The brother-in-law's blood was centrifuged and the serum kept. A week after the first transfusion, we gave another transfusion of about the same amount, from her sister, and, in the meantime, the serum had been given intramuscularly from her brother-in-law. The results seemed to have been favorable. The patient's subjective symptoms improved. Her appetite returned; she started to gain — in a couple of weeks gained about six pounds. Her blood count went up to 4,400,000; her temperature, which had been subfebrile, returned to normal; no further petechiae appeared; no swelling; and the murmur at her heart, which had been very distinct and had developed a rougher timbre during her stay in the hospital, almost disappeared—I say "almost" because I could not hear any murmur, but two of

the other doctors said that they still could hear a very faint murmur at the apex. Since then she has been out of bed, taken walks, and has recently left the hospital. My impression is that the immunotransfusion did something and possibly increased the resistance enough to overcome her trouble—at least temporarily. Of course, it is too soon to judge much about final results. The encouraging fact is that everybody who has published results about this immunotransfusion seems to be impressed with its value—at least in subacute severe septic cases—cases that have been able to survive the first severe inroad of the infection.

HALBERG'S CASES

I shall now give you a short resume of Doctor Halberg's four published cases. The first was a girl, ten years old. Her sickness started with a serious finger infection. Streptococcus viridans was recovered from the blood. The infection spread up the arm and developed into a subpectoral phlegmon and the 16th day after the onset sepsis developed with daily chills and a remittant temperature that went up as high as 106. Her general condition was miserable and seemed beyond hope. She had petechial hemorrhages, nose bleeds and bled from the mouth and intestines. She was first given a simple blood transfusion, seemingly without any results. But eight days afterwards an immunotransfusion was given—the same amount of blood and the same donor, following which the temperature dropped to normal in twenty-four hours, remained down for a few days, then raised a little again and the second week afterwards an empyema developed which was opened and drained. Temperature, after this, gradually subsided—became normal in a couple of weeks. She was released from the hospital and was seen a year afterwards in perfect health.

The second case was a male, fifty years old. This, also, started with a finger infection, with the infection spreading up the arm and a subpectoral phlegmon developed. Following this, a general sepsis. During this time, he was treated with polyvalent antistreptococcic serum, acriflavine and mercurochrome, without any results. Blood culture showed hemolyzing staphylococci. He was given two immunotransfusions, one 27 days after onset of sickness and one 39 days after onset of sickness. During all this time he had had a very high temperature with chills. After the first transfusion, the chills subsided and temperature dropped, but returned again after six days. Therefore, a second immunotransfusion was given and the temperature, after this, went down by lysis, in three days. The patient developed, after the second transfusion, a metastatic abscess which was drained and after three weeks the temperature remained perfectly normal. This patient had developed an endocarditis, during his sickness, which kept him in the hospital for eight months, after which he was released as cured.

The third case was a male, thirty-six years old. Infection in the thumb and little finger, with a malign tendovaginitis spreading up the forearm as a phlegmon, for which multiple incisions were made. The 19th day after onset, he had a chill and temperature arose to 107. The next day, 400 c.c. of blood were given intravenously. The chills and high temperature remained. A streptococcic vaccine, from the metastatic abscess in the femur, was made and nine days afterwards, twenty-two hours after injection of vaccine, 300 c.c. of immunotransfusion was given. After this, temperature became normal in four days and remained so. He was discharged cured.

The fourth case was a boy, three years old. Sickness started with a malign angina, followed by otitis media, later followed by septicopyemia with pyarthrosis in elbow, knee and foot joints. The elbow joint was opened wide—the knee and foot joint were punctured and an autovaccine prepared from the pus. The mastoid was opened on the sixth day. Immunotransfusion was given on the eighth day. Autovaccine, from the knee joint, containing hemolytic cocci in diplococcic form, was made. After the transfusion, there was a gradual fall in temperature, but a marked change, for the better, in the boy's appearance was noted a few hours after the transfusion. The boy made a complete recovery, with the exception of a stiff elbow joint. Both the other joints recovered completely.

I realize that these last four reported cases, to me, seem to be more convincing than my own case.

SUMMARY

I have brought this to your attention thinking that it deserves a little wider publicity and that it might give us an opportunity to try it out in some of our severe infectious cases, as the technique seems to be rather well defined and rather simple—at least simple enough to make it possible for any laboratory to imitate.

The patient, I have reported, was in the office a few days ago and was, seemingly, doing excellently. She was just going down to Chicago on a business trip and stated that she felt better than she has at any time since she was first taken sick, which is better than one year ago.

Embolism During Convalescence From Thyroidectomy for Toxic Goiter Complicated by Auricular Fibrillation*

By JAMES A. EVANS, M. D.
La Crosse
JANE PAXSON, A. B.
Madison

The two cases to be reported are fortunately a rare complication of convalescence from thyroidectomy in cases of auricular fibrillation due to toxic goiter. A careful search of the literature reveals only one reference to such an accident, and our two cases are the only cases in a series of 182 consecutive cases of thyroidectomy on our service or a percentage of 1.1%. Goetsch[3] in an analysis of the mortality in 1,755 goiter operations mentions embolism as a cause of death in three patients. All of these cases had long-standing thyrotoxic myocardial disease, two of them having old endocarditic lesions, and the third long-standing periods of fibrillation, being in a state of fibrillation when operated.

The mechanism of the occurrence of an embolism in this condition is comparable to that following quinidine therapy for auricular fibrillation. In quinidine therapy for auricular fibrillation we have a sudden transition from abnormal to normal rhythm, with a normal contraction of the auricle on a mural thrombus squeezing off an embolus into the general circulation. In cases of death due to peripheral vascular embolism the clot comes from the left auricle; from the right auricle in cases of pulmonary embolism. After toxicity subsides following thyroidectomy it is well known how the heart may suddenly cease fibrillating and the same accident may conceivably occur as after quinidine therapy. This is the very likely mechanism of death in the two following case reports.

Often during convalescence from thyroidectomy a regular rhythm is re-established for short intervals, at first with short periods of normal rhythm, later becoming permanently normal. This fact may account for the heart in these two cases still being found to be fibrillating after the embolism had occurred. It is also difficult to say for certain that in these two cases the normal contraction of the auricle was responsible for the breaking off of a part of the mural thrombus into the general circulation, for it is recognized that embolism is common in untreated fibrillation, some claiming it is just as common. Parkinson and Campbell[10] state that "The chances of clots being detached as emboli when the auricles resume their rhythm has been overemphasized. Embolism is a common event in others with mitral stenosis and fibrillation, whether or not under treatment with digitalis. It was found in four per cent of cases not treated with quinidine, and in three per cent of cases so treated; in 554 of such cases which we have abstracted from the literature, emboli occurred in four per cent, often with only transient effect. Moreover, the change to normal rhythm in cases of paroxysmal fibrillation habitually takes place without mishap."

However, the very frequent reports in the literature of embolism occurring during quinidine therapy (1, 2, 4, 5, 6, 7, 8, 9, 10,

* From the extra-mural preceptorial medical service of the University of Wisconsin, Madison, and St. Francis Hospital, La Crosse.

11, 12, 13, 14, 15) with restitution of normal rhythm suggest that the same mechanism was the factor in causation of the embolism in these two cases of auricular fibrillation due to toxic thyroid, the embolism occurring with resumption of normal rhythm, perhaps for only a few beats, as thyroid toxicity subsided following thyroidectomy.

CASE REPORTS

Case I.—Mrs. W., a white female of 42 entered St. Francis Hospital February 16, 1926, with the complaints of shortness of breath and pounding of the heart. Two years previously she had begun to notice enlargement of her thyroid, tachycardia, and arhythmia. She took some medicine for six months without benefit, then visited another clinic where her basal metabolism was found to be high and her heart so bad as to contra-indicate surgery. She was watched for three months and finally had her superior thyroid arteries ligated and x-ray treatment. After this she improved slowly and the thyroid became normal in size but her heart continued rapid and irregular except during irregular periods of digitalization. Exophthalmos, tremor, and flushing disappeared and her metabolism dropped. On admission she had orthopnoea and edema of the ankles, frequent colds with tachycardia and hemoptysis. She had had no illnesses of the rheumatic group.

Physical examination revealed a white female sitting propped up in bed because of her orthopnoea. Her lips and cheeks were cyanotic. She had no exophthalmos. There was a marked venous pulse in the neck and a rapid irregular precordial pulsation. There was a small scar on either side of the trachea. The thyroid was not palpable. A powerful irregular apex beat was felt in the 6th interspace 12 cm. from the mid-sternal line with a rate of 108 and of variable force and rhythm. A systolic apical murmur was present transmitted into the axilla. The blood pressure was 150/80. The radial pulse was 100 with a deficit of 8. There was no edema present.

Impression: Toxic thyroid, chronic myocarditis, cardiac hypertrophy, auricular fibrillation and mild decompensation.

Laboratory tests: Teleoroentgenogram showed cardiac hypertrophy with a cardiac shape suggestive of mitral stenosis. Basal metabolic rate on day after admission was +48%; on the fifth day +18%; on the tenth day +27%.

The patient was digitalized, put on Lugol's solution and her basal metabolic rate dropped. On February 27 a thyroidectomy was done under local anesthesia. Postoperatively her pulse was slow and irregular under digitalis and her temperature normal. On March 6, while sitting up, she suddenly fell back complaining of vertigo. Physical examination showed her to have a complete flaccid paralysis of the left side of the face and body. In the evening of that day her temperature began to rise, her pulse became fast and irregular, and she developed a cough with thick phlegm. She became dyspnoeic and died in the morning. Autopsy was refused.

It was thought that the patient had died from a cerebral embolism of the right lenticulo-striate artery and that she had probably had an auricular thrombus in the left auricle.

Case II.—Mrs. M., a white woman of 73, was seen for the first time September 9, 1931, complaining of breathlessness and marked weakness. For better than a year she had had gradually increasing dyspnoea on slight exertion and occasional edema of the ankles. For the last 45 years she had had a large goiter which she was sure had never caused her any symptoms. Years before she had suffered from an acute pyelitis.

Physical examination showed a thin, restless, pale, old woman. The important findings were a large nodular thyroid; a diffuse apex beat felt in the sixth interspace to the left of the mid-clavicular line, irregular in rate and intensity; enlargement of the heart to the left and a soft blowing systolic murmur at the apex transmitted to the left; absolute irregularity of the rate and intensity of the heart tones; apex rate of 132, radial of 94, deficit of 38; sclerosis of peripheral vessels; blood pressure approximately 145/100; slight enlargement of the liver; pitting edema of the ankles; positive quadriceps sign and a coarse tremor of the fingers. Diagnosis of toxic adenoma with auricular fibrillation was made and she was put on digitalis and saccharated ferrous carbonate. She was seen two weeks later and her pulse was 108 and regular. Later she was fibrillating again and the diagnosis was made of paroxysmal auricular fibrillation.

On February 7, 1932, she entered St. Francis Hospital. From February 8 to February 11 her basal metabolic rate went from +47% to +32%. An electrocardiogram established the diagnosis of auricular fibrillation. On February 11 a ligation of both superior thyroid arteries was done and on the 15th of February radium was applied. She improved rapidly and was discharged on the 16th still slowly fibrillating at a rate of 72. At home she seemed much better. On the 21st she developed sudden severe abdominal pain with nausea and vomiting. She became rapidly worse, had frequency and dysuria, a temperature of 104, and a rapid, irregular pulse. The abdomen was tender and somewhat rigid. A catheterized specimen of urine showed pus and albumin. The possibilities of her having a flare-up of her old pyelitis or a mesenteric thrombosis were considered. She died early in the morning of the 23rd.

Autopsy by Dr. John Miles showed death to be due to thrombosis of the superior mesenteric artery and a mural thrombus in the left auricle. In addition there was found evidence of cystitis, pyelitis, chronic nephritis, fatty degeneration of the liver and absence of the middle lobe of the right lung.

(Continued on page 492)

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EDITORIALS

EDWARD EVANS

IN THE opinion of this writer, Dr. Edward Evans was one of the greatest men in the Wisconsin medical fellowship, and certainly one of the best loved. In addition to the tug on the heart strings, his death breaks another link between the essentially frontier state of wide open spaces and that of today with its increasingly closer packed, more interdependent, but less neighborly people.

More than the commonalty of mankind, Edward Evans possessed the ability to look forward and backward fearlessly and without undue confusion. Venerating the best traditions and heritages of the past, he looked toward the future hopefully and confident that its promises would ultimately be fulfilled. Withal, however, he was not essentially a complacent man, nor overpatient. Far from it. He could hit hard from the shoulder—and often did—against what looked to him like smugness, and willful efforts to block progress. But he gave a no less vigorous support to men and measures that appealed to his splendid idealism.

Edward Evans was a thoroughly competent surgeon; but even more, a *physician* in the highest sense. But even above that he desired to be, and was, "a good citizen." In his Presidential Address at the 1910 session of the State Medical Society of Wisconsin he said:

> "We must not forget that we are not doctors only but citizens also, and as such vitally concerned in everything that pertains to the uplift of our people, not only in medicine, but in culture, in pure science, in agriculture, in law, in domestic and in political science, and in all those things that influence the social improvement and the physical betterment of the citizens."

One of his greatest interests was in Education. Education—not as an end but as a means of increasing and improving service; and as a preparation for receiving as well as for giving. He wanted to know the Truth and with characteristic generosity wanted to make what he and others possessed of it, and still could find of it through research, available to the service of everybody who could profit by it. Venerating the science of Medicine and every other science that contributes to it, he was no intellectual snob. On the contrary, he demanded that knowledge be put to productive work. And so we found him among the far-visioned pioneers of various public welfare movements.

As a regent of the University of Wisconsin, he was little more interested in the Medical School than in the Extension Division's efforts to disseminate knowledge and information to the masses. Between his exacting demands for high standards in medical

training and his interest in general education and culture, the harmonizing note was sounded in another passage from the same address:

> "As we study more the scope and possibilities of medical science, the more clearly do we see its close relation to the humanities—to philosophy, to the social sciences, and, be we sceptic or Christian, we must weave into the very warp and woof of our professional being a recognition of those relationships if we would be educated, competent, successful medical practitioners."

Unquestionably, the dominant characteristic of this rare man was Friendliness. Doctors and nurses, patients and servants, students and neighbors, all have their little personally treasured anecdotes of how simply and unostentatiously he conferred a generous service of some kind that often marked a milestone in the life of the recipient.

It was a rare privilege—the memory of which many will carry to their own graves—to have known Edwards Evans intimately and to have been privileged to be with him in his home, his operating room, his consulting room and at the meetings of the State Medical Society of Wisconsin, in the best interests of which he served so unselfishly.

—H. E. D.

USE OF ALCOHOL IN FEVERS

AS AN Interne under one of the great physicians of the past decades we gave alcohol freely to all very ill febrile cases. Gradually the practice was abandoned. When in charge of the Milwaukee County Hospital some years ago I had all brandy and whiskey removed from the wards for a period beginning about 1916 until my service terminated in 1922. Although I have no statistics upon which to base my opinion, I am sure that the mortality of typhoid fever, pneumonia, septicemia, etc., was no greater than it had been previously. The typhoid fever mortality and complications were reduced because of the introduction of other measures. This I reported at one of our State Society meetings.

Feeling as I have felt for many years that alcohol is not a cardiac stimulant, it has relatively little value as a food and has been definitely shown to be a depressant to the circulation, I am glad to review briefly the experience of Dr. J. D. Rolleston at the Western Fever Hospital, London,* because it confirms what I have maintained for some years. When he took charge he banished alcohol. In the four years since it has not been used the case mortality at his hospital was the lowest of the nine fever hospitals in London where brandy and whiskey are used freely. "Dr. Rolleston concludes not only that the recovery rate was not lowered by the omission of alcohol but also that convalescence was as rapid as in the cases treated with various alcoholic beverages in the other hospitals.

"In the ambulance for the conveying of patients to the fever hospitals, brandy has continued to be supplied for use on the journey. The nurses have not been forbidden to use it but have been ordered to give a report of every case in which they considered its administration necessary. The result of this order has been that since Jan. 1, 1927, only 3 ounces and 3 drachams have been used up to the time of the report (Nov. 1, 1931), during which period many thousands of patients have been conveyed."

So convinced are the nurses of the uselessness of brandy that since May 17, 1928, none has been used in the ambulance service.

This is not to be interpreted as a plea for our present era of prohibition. The writer is not a prohibitionist. No crusade is begun to take liquor out of hospitals. The only intention is to show that alcohol has no value as a drug in the treatment of fevers.

As a stomachic, an appetizer, in the depression states of old people it often seems to help to create an appetite. So do not let us discard it completely but let us realize that as a cardiac stimulant or food in various fevers it really has not the virtues which have been attributed to it. L. M. W.

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* J. A. M. A. 98:1578, 1932 (Apr. 30).

THE PRESIDENT'S PAGE

LEST WE FORGET

IN AMERICA for many years we have been thinking largely, one might almost say solely, in dollars and cents. The present economic chaos has not helped the situation. However, I believe that we are beginning to give more consideration to human values than we have in some years past.

What is true generally is true specifically in the field of medical practice. While it is not invariably true that the doctor's account is the last one paid, it is a fact that modern business methods of collection and forcing payment have not been generally adopted by the profession and the public, aware of this, has acted accordingly. This leaves the profession, in large figure, a creditor group.

However, the position of the practitioner in the social body has been determined and maintained not by what he has accumulated, but by what he has given. The public knows that the doctor is much more interested in service than in profits, and we in the profession must not destroy this attitude in the minds of our clientele. It has resulted from years of devoted and helpful effort for social wellbeing. While we must safeguard our living standards and are justified in demanding returns for our labor, still we must ever demonstrate that it is in the service that we render that we are particularly interested. The survey being made this year under instructions from the House of Delegates has revealed many thought provoking data, and among other things clearly demonstrated that we have been doing our full share to lighten the economic burden of those who have been overladen. It is evident, too, that this has often been done at great personal sacrifice on the part of the physician.

But despite these facts the time has come, it would seem, when it is better not to overemphasize the economic and financial aspects of the depression as it affects us, and to avoid too free a public discussion of these economic problems. It is much to our credit and to our honor that people have come to feel that the medical profession is the most tolerant, the most just, and the most kindly creditor in its relation to its debtors, and that really its prime interests are not in the financial but in the service relations.

With this in mind let us maintain as our first consideration the advancement of the profession, its educational program and our personal development to the end of a better service to our patrons. Let us be most assiduous in securing for the public the best medical care that it is possible to provide. Let us be most interested in the intention and extension of the service which we render. It is altogether probable that if we do this, which in the past has secured for us our social standing, our professional ability, and the public gratitude, we shall not have cause to discuss or to worry about our finances. Let us think more of service and less of profits.

THE STATE MEDICAL SOCIETY OF WISCONSIN

ORGANIZED 1841

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LIST OF EXECUTIVE OFFICERS OF COUNTY MEDICAL SOCIETIES

County	President	Secretary
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Barron-Washburn-Sawyer-Burnett	C. F. Cronk, Cameron	A. D. Galloway, Barron.
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Calumet	A. C. Engel, New Holstein	J. W. Goggins, Chilton.
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Columbia	K. A. Snyder, Portage	H. Y. Fredrick, Westfield.
Crawford	A. E. Dillman, Steuben	C. A. Armstrong, Prairie du Chien.
Dane	F. F. Bowman, Madison	F. L. Weston, Madison.
Dodge	E. P. Webb, Beaver Dam	A. W. Hammond, Beaver Dam.
Door	John Hirschboeck, Forestville	
Douglas	H. A. Sincock, Superior	C. H. Christiansen, Superior.
Eau Claire and Associated Counties	E. E. Tupper, Eau Claire	P. G. Spelbring, Eau Claire.
Fond du Lac	J. C. Yockey, Fond du Lac	H. R. Sharpe, Fond du Lac.
Grant	C. M. Schuldt, Platteville	M. B. Glasier, Bloomington.
Green	W. B. Gnagi, Sr., Monroe	J. F. Mauermann, Monroe.
Green Lake-Waushara-Adams	G. E. Baldwin, Green Lake	A. J. Wiesender, Berlin.
Iowa	S. R. Ridley, Mineral Point	H. M. Walker, Dodgeville.
Jefferson	A. C. Nickels, Watertown	A. A. Busse, Jefferson.
Juneau	C. A. Vogel, Elroy	A. T. Gregory, Mauston.
Kenosha	A. Schlapik, Kenosha	W. H. Lipman, Kenosha.
La Crosse	R. L. Eagan, La Crosse	G. D. Reay, La Crosse.
Lafayette	R. B. Quinn, Darlington	W. B. Williams, Argyle.
Langlade	C. E. Zellmer, Antigo	J. C. Wright, Antigo.
Lincoln	F. L. Kelley, Merrill	W. H. Bayer, Merrill.
Manitowoc	C. H. Barnstein, Newton	E. C. Cary, Reedsville.
Marathon	Joseph F. Smith, Wausau	Verne E. Eastman, Wausau.
Marinette-Florence	T. J. Redelings, Marinette	C. H. Boren, Marinette.
Milwaukee	P. M. Currer, Milwaukee	Theo. Wiprud, Ex. Sec'y, Milw.
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Oconto	R. J. Goggins, Oconto Falls	G. W. Krahn, Oconto Falls.
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Polk	L. O. Simenstad, Osceola	Geo. B. Larson, Frederic.
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Price-Taylor	F. W. Mitchell, Medford	G. L. Baker, Westby.
Racine	C. O. Schaefer, Racine	Susan Jones, Racine.
Richland	W. C. Edwards, Richland Center	G. Benson, Richland Center.
Rock	G. S. Metcalf, Janesville	E. C. Hartman, Janesville.
Sauk	Roger Cahoon, Baraboo	A. C. Edwards, Baraboo.
Shawano	C. E. Stubenvoll, Shawano	L. W. Peterson, Shawano.
Sheboygan	H. F. Deicher, Plymouth	A. C. Radloff, Plymouth.
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Waukesha	J. C. Hassall, Oconomowoc	J. F. Wilkinson, Oconomowoc.
Waupaca	R. K. Irvine, Manawa	F. J. Pfeifer, New London.
Winnebago	G. E. Forkin, Menasha	M. C. Haines, Oshkosh.
Wood	F. X. Pomainville, Wisconsin Rapids	W. G. Sexton, Marshfield.

SOCIETY PROCEEDINGS

BROWN-KEWAUNEE

The May meeting of the Brown-Kewaunee County Medical Society was held in the old Fort Howard hospital, Green Bay. Following a buffet lunch an informal business meeting was held and it was decided by the members to extend an invitation to the State Medical Society of Wisconsin to hold its 1934 meeting in Green Bay,—the year of the Nicolet Tercentennial at Green Bay.

The physicians also voted to endow a room in the old Fort Howard hospital building and to dedicate it to the memory of Dr. William Beaumont.

Drs. M. H. Fuller and A. J. McCarey were appointed to represent the Society in the new Civic Council which is being formed, and Drs. P. R. Minahan and O. A. Stiennon were appointed to give assistance to the movement to encourage hobby projects among the aged. The latter appointments were made after the Society had passed a resolution commending the Press-Gazette for beginning the "Grandmas and Grandpas Hobby Contest" and acknowledging it as "a health conserving and laudable program meriting general interest and support."

Mr. R. A. Kennedy, managing editor of the Press-Gazette, was the only speaker of the meeting. He discussed the "service record" of the old hospital building and the relations of the press and the profession. The members accorded a rising vote of thanks at the conclusion of the paper.

CLARK

The annual meeting of the Clark County Medical Society was held at the Hotel Robinson, Colby, May 26th. Dinner was served at six-thirty o'clock.

Immediately after the dinner, Dr. H. H. Milbee of Marshfield read a paper on "Coronary Disease," and Dr. J. E. Gonce, Jr., associate professor of pediatrics, University of Wisconsin, spoke on "Restlessness in Infancy."

Officers for 1931 were re-elected. There were twenty-two physicians present. A. L. S.

EAU CLAIRE

A meeting of Eau Claire and Associated Counties Medical Society was held on Monday, June 13th, at Mount Washington Sanatorium, Eau Claire. Dinner was served at six-thirty o'clock after which the following program was presented:

"The Diagnosis of Tuberculosis" by Dr. George Beebe, Eau Claire.

"The Organization of the Study of Cancer under the Auspices of the State Medical Society of Wisconsin" by Dr. W. D. Stovall, Madison.

FOND DU LAC-WINNEBAGO

A joint meeting of the Fond du Lac and Winnebago County Medical Societies was held at Sunny View Sanatorium at Winnebago, Wis., to inspect the new preventorium nearly completed. Dinner was served, followed by a program which included a discussion and study of surgical methods in the treatment of tuberculosis. Dr. Joseph W. Gale, associate professor of surgery, University of Wisconsin, was the speaker of the evening.

GRANT

At a meeting of the Grant County Medical Society held at Lancaster on June 7th, the following officers were elected: President, Dr. C. M. Schuldt, Platteville; Vice-president, Dr. Rush Godfrey, Lancaster; Secretary-Treasurer, Dr. M. B. Glasier, Bloomington; Delegate, Dr. E. H. Spiegelberg, Boscobel; Alternate delegate, Dr. M. A. Bailey, Fennimore; Censors, Drs. C. M. Schuldt, F. E. Blackburn, Cassville and E. C. Howell of Fennimore.

Two new members were received into the Society, —Dr. C. F. Harris, Bloomington and Dr. F. S. Tuffley of Boscobel. M. B. G.

ROCK

Monthly meetings of the Rock County Medical Society and the Woman's Auxiliary were held in the Monterey Hotel, May 31st. Dinner preceded each meeting.

Dr. W. W. Bauer, director of the bureau of health and public instruction, American Medical Association, talked to the Auxiliary on the wide scope of Hygeia Magazine.

"Diseases of the Heart" was discussed by Dr. Arthur R. Elliott, professor of medicine, University of Chicago.

An illustrated lecture was given by Mr. Robert G. Morey of the Brook Hill Laboratories, Genesee Station. Mr. Morey discussed the food value of vitamin D as a food.

WOOD

Members of the Wood County Medical Society met on June 3rd at the Hotel Charles, Marshfield, for their regular dinner meeting.

After the dinner a program was held at St. Joseph's hospital and papers were read by Drs. K. H. Doege, H. H. Milbee, K. W. Doege, all of Marshfield, and Wallace Nelson of Wisconsin Rapids.

FOURTH COUNCILOR DISTRICT

The seventh annual meeting of the Fourth Councilor District was held on June 7th at the Grantland Club Rooms, Lancaster, at two-thirty in the afternoon.

The following program was presented:

"Differential Diagnosis of Hypertrophic Pyloric Stenosis" by Dr. H. K. Tenney, associate professor of pediatrics, University of Wisconsin Medical School.

"Bright's Disease and its Management," by Dr. Francis D. Murphy, Marquette University School of Medicine.

"Surgical Phases of Cancer of the Colon," by Dr. C. F. Dixon, Mayo Clinic, Rochester.

"Case Reports. 1, Duodenal Diverticulitis; 2, Diverticulitis of the Sigmoid with Pulmonary Embolism," by Joseph Dean, Dean Clinic, Madison.

"Some Points in Diagnosis," by Dr. H. A. Marsh, Jackson Clinic, Madison.

A fried chicken dinner was served by the ladies of the Lutheran church at six o'clock. There was a good attendance at the meeting and the splendid program was appreciated by all. M. B. G.

SIXTH COUNCILOR DISTRICT

A meeting of the Sixth Councilor District medical societies was held on Thursday afternoon and evening of June 9th. Nearly two hundred physicians attended from Brown–Kewaunee, Door, Outagamie, Winnebago and Fond du Lac county medical societies.

The afternoon meeting was held at St. Elizabeth's Hospital, Appleton, at two o'clock with the following speakers and their subjects on the program:

"Treatment of Fractures" with motion picture demonstration by Dr. Ralph Carter of Green Bay.

"Medical Clinic. Demonstration and discussion of Heart Disease" by Dr. N. C. Gilbert, associate professor of medicine, Northwestern University.

"Varicose Veins and Ulcers",—demonstration and discussion of the treatment of varicose veins and ulcers by Dr. Ralph McPheeters of Minneapolis.

"Treatment of Joint and Back Injuries" by Dr. Harry Mock, associate professor of surgery, Rush Medical College.

Dr. Morris Fishbein, editor of the Journal of the American Medical Association, was the guest speaker at the dinner meeting in the Conway Hotel at six thirty o'clock. His subject was "Present Day Trends of Private Practice in the United States."

GREEN BAY ACADEMY OF MEDICINE

Dr. W. E. Mueller was elected president of the Green Bay Academy of Medicine at the annual meeting held at the Hotel Northland in May. Dr. J. R. Minahan was elected vice-president, and Dr. J. C. Colignon, secretary and treasurer.

Dr. Arthur E. Hertzler of Halstead, Kansas, professor of surgery, University of Kansas, gave the principal address at this meeting which was followed by a talk by the retiring president, Dr. Herman Hendrickson.

MILWAUKEE PEDIATRIC

The following program was presented at the meeting of the Milwaukee Pediatric Society held at the Milwaukee Children's Hospital on June 8th:

"The Significance of the Vitamins in the Nutrition of the Child" by F. W. Schulz, M. D., Chicago.

"Congenital Heart Disease" by H. B. Miner, M. D., Milwaukee.

THE WOMAN'S AUXILIARY

Mrs. Orvil O'Neal, Ripon, Editor

The Woman's Auxiliary of The Medical Society of Milwaukee County held its last meeting of the season on May 20th. Reports of the various committees were presented and Dr. W. W. Bauer, director of the Bureau of Health and Public Instruction of the American Medical Association addressed the members on "Modern Trends in Public Health Work."

The Milwaukee Auxiliary was organized in December, 1931, and to date has 237 members. The Auxiliary is beginning to lay tentative plans for the national convention to be held in Milwaukee in 1933.

CRAWFORD MEMORIAL

At the suggestion of the Jane Todd Crawford Memorial Committee of the Woman's Auxiliary to the Kentucky State Medical Association, the radio talk "A Pioneer Heroine" was presented over the University of Wisconsin radio station, WHA, on Tuesday, December 15, 1931, at 12:15 P. M. At the suggestion of our state president this short address is published, following:

"December 13th was the 122nd Anniversary of one of the most courageous acts of a woman and the most brilliant achievement of a man. Mrs. Jane Todd Crawford, pioneer heroine of surgery was born December 23, 1763, in Virginia. In December, 1809, when Jane Todd Crawford was 46 years of age, two physicians interested and puzzled by her peculiar illness, called in consultation Doctor Ephraim McDowell, a practitioner of fourteen years.

"No historian was present at this first interview of physician and patient. Doctors, in those days, made few notes. Nurses, secretaries, and stenographers did not exist as we know of them today, but following is the graphic description of this visit by Dr. Samuel Gross:

" 'After a most thorough and critical examination, Dr. McDowell informed his patient, a woman of un-

usual courage and strength of mind, that the only chance for relief was the excision of the diseased mass (an ovarian tumor). He explained to her, with great clearness and fidelity, the nature and hazard of the operation, he told her that he never performed it, but that he was ready, if she were willing, to undertake it, and risk his reputation upon the issue, adding that it was an experiment but an experiment well worthy of trial. Mrs. Crawford listened to the surgeon with great patience and coolness, and, at the close of the interview, promptly assured him that she was not only willing, but ready to submit to his decision; asserting that any mode of death, suicide excepted, was preferable to the ceaseless agony which she was enduring, and that she would hazard anything that held out even the most remote prospect of relief.'

"The crude condition of the Crawford home made it essential that Mrs. Crawford be moved to Dr. McDowell's office in Danville, Kentucky,—sixty miles away. With her usual fortitude Mrs. Crawford made the journey on horseback. At the end of the journey waited Dr. McDowell who had improvised a primitive operating room. With the help of his nephew, Dr. James McDowell, Dr. Ephraim McDowell performed the life-saving operation.

"Mrs. A. T. McCormack has graphically drawn the picture of the scene: 'For a moment, let us go back to that primitive operating room improvised in the home of Doctor McDowell in Danville, which is still standing, and visualize the scene.

" 'The room is rather bare and quite cold, too, for it is a wintry day, this December 13, 1809. In the center of the room, near the window, is a long wooden table covered with a folded blanket. On this lies a woman patient—not in surgical gown and stockings, but apparently, fully dressed, her head resting on a pillow covered with a white slip.

" 'She was a courageous woman, a quiet, practical woman, unafraid of plunging into the unknown, a pioneer all her life, used to hardships and the hazards of the frontier, yet a woman of fine feeling and tender sensibilities. But she was pioneering in a new field. Pioneering for the womanhood of all coming generations.'

"Five days after the operation, Dr. McDowell found Mrs. Crawford up, making her bed, and in twenty-five days she returned home on horseback over the stony roads.

"This courageous woman was 46 at the time of the operation, and, as a result of it her life was extended thirty-one more years and she died in 1841 at the age of 78. That which is an accepted fact today, the sureness of surgery, was an experiment for those days. Without a doubt every woman, at some time or other, has had occasion either for herself or for some loved one to be grateful to Jane Crawford for her fortitude in preparing the way in cooperation with Dr. McDowell for abdominal surgery which has, in these modern times become a relatively simple, safe and not unusual procedure.

"Upon the occasion of the dedication of the monument to Dr. McDowell at Danville in 1879, Doctor Lewis Sayer of New York, then President of the American Medical Association, said: 'Another fact strikes me very forcibly, and that is the heroic character of the woman who permitted this experimental operation to be performed on her.' The Woman's Auxiliary to the Kentucky State Medical Association plan to erect a memorial to Jane Todd Crawford.

"In the history of science and medicine there are many examples of great heroism and it is the promotion of such ideals that offer an opportunity for the development of the character of children. The study of the lives of the pioneers of medicine and public health opens a rich field for the inculcation of high standards of conduct and highest ideals of life."

NEWS ITEMS AND PERSONALS

Drs. Frank Mulvaney of Marion and Victor F. Marshall of Appleton were guests of Dr. W. H. Finney of Clintonville for a week's outing at Dr. Finney's hunting lodge on Lake Kapatogama near International Falls.

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Dr. and Mrs. K. W. Doege, Marshfield, returned on May 21st from their trip abroad. The greater part of their time was spent in Germany, visiting also in London.

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Dr. C. F. Dull, Richland Center, was appointed local physician for the Northland Greyhound Bus Lines to succeed the late Dr. J. M. Ross.

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Mrs. Beulah Muzzy Adams, 62, wife of Dr. George F. Adams of Kenosha died on May 25th at her home in Kenosha after a long illness. Besides her husband she is survived by one son and a daughter.

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Dr. S. E. Gavin of Fond du Lac has been promoted from the rank of major to colonel in the Wisconsin National Guard. The appointment became effective May 17th and he has been assigned to the Governor's staff.

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Presentation of a valuable medical set to the Public Museum of Green Bay was made by Dr. Joseph L. De Cock, Green Bay, recently. The set is from seventy-five to one hundred years old. It includes two types of scarificators; alcohol lamp; suction cups and a cupping device.

Dr. G. S. Metcalf, formerly with the Munn–Farnsworth Clinic, Janesville, on June 1st became associated with Dr. Frank W. Van Kirk of Janesville.

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Dr. Ralph M. Carter, Green Bay, spoke before the staff meeting of Beloit Municipal Hospital on May 5th, on the subject of "Fractures of the Femur." On May 6th, he spoke before the Macon County Medical Society of Decatur, Ill., on the same subject.

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Dr. T. D. Smith and Dr. Geo. H. Williamson, both of Neenah, delivered addresses before the graduating class of the Theda Clark Hospital School of Nursing.

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Dr. F. J. Woodhead, Waukesha, was appointed city physician to succeed Dr. Arthur J. Williams.

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Dr. George R. Reay of La Crosse was elected president of the Wisconsin Homeopathic Medical Society at its annual meeting in Madison in June. Dr. Reay also appeared on the program with a paper on "Safe Medicine and Its Problems."

Other officers elected for the coming year are Dr. G. E. Crosley, Milton, vice-president; Dr. F. E. Kosanke, Lomira, secretary-treasurer; Dr. John E. Guy, Milwaukee, Dr. Wilbur N. Linn, Oshkosh, and Dr. W. T. Clarke of Janesville on the legislative committee.

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At a meeting of the city council of Clintonville in June, an appropriation of $300 was made to be used for equipment of the new community hospital which is being prepared for use. Drs. J. H. Murphy and F. C. Walch of Clintonville appeared before the council in the interest of the hospital.

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What the family physician of thirty years ago meant to his community was the subject of an address by Dr. S. G. Schwarz, Marshfield, before a meeting of the Marshfield Rotary Club.

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Dr. J. C. Elsom, professor of Physical Education, University of Wisconsin, gave an address before the 88th annual meeting of the American Institute of Homeopathy held in Washington, D. C. in June. He also read a paper on "Heat and Light in Disease," before the National Society of Physical Therapeutics.

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The American Board for Ophthalmic Examinations will hold an examination in Montreal on Monday, September 19, 1932, at the time of the meeting of the American Academy of Ophthalmology and Oto-Laryngology. Necessary applications for this examination can be procured from the Secretary, Dr. William H. Wilder, 122 South Michigan Ave., Chicago, and should be sent to him at least sixty days before the date of the examination.

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Members from out of the city who visited the State Society office during June included Drs. Robert Reagles of Arlington; M. D. Bird of Marinette; W. C. Becker of Watertown; R. L. MacCornack, Whitehall; Otho A. Fiedler, Sheboygan; and the following from Milwaukee,—Gilbert E. Seaman, D. E. W. Wenstrand and John Huston.

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Dr. I. E. Ozanne of Neenah spoke before a meeting of the Parent-Teachers Association of Washington School, Neenah, discussing a child health program for the vacation months.

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Dr. H. M. Lynch, formerly of Milwaukee, on June first opened offices at 147 North Main St., West Bend, Wisconsin, for the general practice of Madison.

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Dr. H. Hendrickson, was elected president of St. Mary's Hospital medical staff, Green Bay, at the annual meeting of the staff. Dr. T. J. Oliver was chosen vice-president and Dr. J. C. Colignon was reelected secretary-treasurer. Dr. A. J. McCarey and Dr. E. S. Knox were named to the executive board.

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"The Development of X-Ray" was the subject of an address by Dr. S. D. Greenwood of Neenah before the Menasha Kiwanis Club.

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At the June meeting of the Afton P. T. A., Dr. Carl N. Neupert of Janesville gave a talk on child health.

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A golden jubilee reunion of the class of 1882 of the University of Wisconsin was held in Madison on Saturday, June 18th, with Dr. Louis R. Head, Madison, acting as president of the class. Fourteen of the forty-eight surviving members of the class attended the reunion.

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Dr. George H. Ewell, Madison, attended clinics at Brady Urological Institute, Baltimore, in June.

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Dr. Arthur J. McCarey of Green Bay attended the twenty-year reunion of the class of 1912 of Rush Medical College, and spent several days in Chicago visiting Alumni Clinics arranged especially for the occasion.

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MILWAUKEE

Dr. W. W. Hume has announced the opening of his new office in the Goldsmith Building, 425 E. Wisconsin Avenue. He formerly was located in the Bankers Building at 208 E. Wisconsin Avenue.

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One June 8th, Dr. D. W. Roberts spoke before the Milwaukee Knights of the Round Table on the subject of "Keeping Mentally Fit."

Dr. Millard Tufts was the speaker at the June 15th meeting of this same group. "Are You Overweight?" was the title of his address.

Dr. Samuel E. Kohn sailed on June 2nd for a three months' trip abroad where he expects to study in Berlin, Dusseldorf, Breslau, Vienna, and Paris.

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Dr. Roy W. Benton was appointed health commissioner of Shorewood on May 7th, to succeed Dr. W. G. Darling.

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Dr. Eben J. Carey, professor of anatomy, Marquette University School of Medicine, spoke on "A Century of Progress in Medicine" at the meeting of the Milwaukee Gyro Club on June second.

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Word has been received recently at the office of the Wisconsin Reserve District that Dr. Harvey E. Webb has been promoted from Lieutenant Colonel to Colonel in the Medical Detachment of the Reserve Corps.

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Dr. Samuel Plahner addressed the Milwaukee Teachers' Association at their meeting on June 7th, on the subject of "Why Children Tell Lies."

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Radio health talks, sponsored by the State Board of Health and delivered by Mr. Theodore Wiprud, executive secretary of the Medical Society of Milwaukee County over WTMJ weekly, have been concluded for the seasons. They will be resumed in October.

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Dr. and Mrs. Harry A. Sifton left Milwaukee on June 7th for their summer home at Sister Bay, Door County, Wisconsin.

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Reverend Herman L. Fritschel, Superintendent of the Milwaukee Hospital, presented diplomas to forty-one nurses, graduating from the Milwaukee Hospital School of Nursing, at the commencement exercises held in the Grand Avenue Congregational Church on June 9th.

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Dr. S. M. Turkeltaub, who for some time has been associated with Dr. Walter M. Kearns, left for New York on June 15th to take up a surgical residency at Mt. Sinai Hospital for a year, after which he expects to devote some time to postgraduate work at Columbia University School of Medicine.

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Dr. Edith G. Hamilton, who has practiced medicine in Milwaukee for a number of years, left on June first to take up residence in Hemaruka, Alberta, Canada, where she expects to resume her practice.

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Dr. and Mrs. Arthur A. Holbrook of Boston, Massachusetts, have been the guests for the past few weeks of Dr. and Mrs. Arthur T. Holbrook.

On June 6th, they, with Mrs. Arthur T. Holbrook, left for the latter's summer home at Brule, Wisconsin.

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Dr. R. E. Bushong, Milwaukee County psychiatric director, was the guest speaker at the meeting of the Civitan Club on June the 7th, at which time he addressed the members on "Mental Maladjustment."

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Dr. H. B. Podlasky announces the removal of his office from 536 W. Wisconsin Avenue to the Goldsmith Building, 425 E. Wisconsin Avenue.

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Dr. and Mrs. Robert W. Blumenthal left on June 15th for a month's tour of the West. They expect to visit the Yellowstone and Glacier National Parks.

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Dr. James C. Sargent, president-elect of The Medical Society of Milwaukee County, was the guest speaker at the June 16th meeting of the Milwaukee Gyro Club. He addressed the members on "The High Cost of Sickness."

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Francis H. McGovern, son of Dr. and Mrs. John J. McGovern, was graduated from the University of Pennsylvania School of Medicine on June the twenty-second. He will serve as an intern at the Wisconsin General Hospital at Madison.

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On July the ninth, the marriage of Miss Gertrude Zivnuska, daughter of Dr. and Mrs. J. F. Zivnuska, to Mr. E. Walter Rickmeyer of Chicago will take place in the Marquette University Chapel.

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Mr. Frederick J. Stoddard, son of Dr. and Mrs. Charles H. Stoddard, has arrived in Milwaukee to spend the summer with his parents. He is a student at Bowdoin College in New Brunswick, Maine. Charles H. Stoddard, Junior, who attends the University of Michigan, and has been at home since the close of his classes, left on June 27th to attend an eight-week summer session of the forestry department of the University of Munising, Michigan.

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The Wisconsin Pharmaceutical Society will hold its annual meeting on July 12–13–14 at the Hotel Schroeder. Dr. James C. Sargent will speak at the July 13th session.

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The American Physiotherapy Association held its National Convention in Milwaukee from June 27–30, at the Hotel Pfister. The following program was presented:

Address of Welcome—Dr. Herman C. Schumm.

The Public Health Nurse and Physiotherapy—Miss Edna L. Foley.

Wisconsin's Program for Crippled Children—Mrs. G. Earl Ingram.

Scoliosis—Dr. Eben J. Carey.

Congenital Dislocation of the Hip—Dr. W. P. Blount.

Psychic Factors in Rehabilitation—Dr. Harry Tabachnick.

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Dr. T. L. Harrington spoke on "Newer Things in Medicine" at the meeting of the Business and Professional Women's Club on June 7th.

Dr. and Mrs. Carl Henry Davis and children moved to their summer home at the Wisconsin Dells, Wisconsin, on June the 10th.

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Dr. and Mrs. Louis M. Warfield and children left Milwaukee on June 21st for a week's motor trip.

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Dr. A. C. Sidler returned to Milwaukee the early part of June from a trip around the world. He witnessed some of the fighting between the Chinese and Japanese at Shanghai. After trying to reach Shanghai, Dr. Sidler was forced to return to Peiping.

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Dr. Norbert Enzer, pathologist at Mt. Sinai Hospital, has opened office in the Goldsmith Building, 425 E. Wisconsin Avenue.

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At the meetings of the educational committee, held on June 2nd and 9th, the lists of physicians, classified according to their types of practice, were studied and revisions considered.

Tentative plans to sponsor the following postgraduate courses during 1932–1933 were made: Orthopedics, Roentgenology, Gynecology and Obstetrics, Dermatology, Eye, Ear, Nose, and Throat, Neurology.

The Committee approved a letter to members in regard to the pediatrics course, sponsored by the University of Wisconsin Extension Division and the State Medical Society, to be held in Milwaukee this summer.

The program committee met in the Mariner Tower on June 3rd to consider a speaker for the annual meeting of The Medical Society of Milwaukee County in December. The committee agreed that Dr. Olin West, Secretary of the American Medical Association should be obtained if possible for this meeting, and the Secretary was instructed to forward to Dr. West an invitation to speak.

Plans for the October, November, and December meetings were suggested and considered, but as yet they are tentative.

A suggestion was made, at the meeting of the collection service committee in the Mariner Tower on June 7th, that the Medical Business Bureau endeavor to make arrangements whereby they would be notified by insurance companies at the time settlements are made in accident cases.

Mr. Gramling, manager of the Bureau, informed the committee of the activities of the Bureau, and told them of some of the problems which confront them in making collections.

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At the meeting of the membership committee in the Mariner Tower on June 8th, consideration was given to applicants for membership in the Society. Members of the committee agreed to contact as many interns as possible with a view to securing them as intern members.

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Tentative plans for the annual golf tournament to be sponsored by the Milwaukee County Physicians' Golf Association and The Medical Society of Milwaukee County were made at a meeting of the Association and representatives of the Society on June tenth. Each member agreed to secure as much information as possible regarding clubs available for the tournament, before the next meeting which is to be called early in July.

The date set for the tournament was July 21st.

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When the social committee met in the Mariner Tower on June 15th, definite plans for the third annual picnic of The Medical Society of Milwaukee County were made. It was decided to hold the picnic at the Fred Usinger Estate which had generously been offered by Mr. Usinger. A program for the entertainment of guests was mapped out and members of the committee assigned to various sports and games.

Births

A son to Dr. and Mrs. J. M. Beffel, Jr., Milwaukee on May 12th.

A daughter to Dr. and Mrs. E. C. Grosskopf, Milwaukee on May 19th.

A son to Dr. and Mrs. Leonard Schneeberger, Milwaukee on May 19th.

A son to Dr. and Mrs. Leonard C. J. Olsen, Milwaukee on May 21st.

A daughter to Dr. and Mrs. Norbert Enzer, Milwaukee on June 2nd.

A son to Dr. and Mrs. Karl Schlaepfer, Milwaukee on June 7th.

A son to Dr. and Mrs. Victor Taugher, Milwaukee, on June 14th.

Engagements

On May 31st, Mr. and Mrs. A. G. Logemann announced the engagement of their daughter, Miss Charlotte, to Dr. John O. Dieterle.

The engagement of Dr. Roman E. Galasinski, Milwaukee, to Miss Florence Stamm, Milwaukee, was announced on June 18th.

Marriages

Dr. Joseph J. Kronzer, Oshkosh, to Miss Lucille Wagner, Cleveland, Wis., on May 23rd.

Dr. Gamber F. Tegtmeyer, Milwaukee, and Miss Margaret Louise Brown, were married on June 18th. After a wedding trip, Dr. and Mrs. Tegtmeyer will go to St. Louis where Dr. Tegtmeyer will serve his internship at St. Louis Children's Hospital.

Deaths

Dr. Edward Evans, La Crosse, a former President and Chairman of the Council of the State Medical Society, died at his home on June first after an illness of three years.

He was born in Beechwood, Ontario, March 7, 1860, and graduated from Toronto Model School in 1883 and McGill University, Montreal, in 1887. In 1888 he came to LaCrosse to establish his practice. Two years later he went to New York to take post-graduate work and then returned to La Crosse and began specializing in surgery. He was chief of staff of St. Francis Hospital, La Crosse, until his retirement December 15, 1928. Dr. Evans was actively connected with the Catholic Hospital Association from the time of its organization and was associate editor of "Hospital Progress" until 1927. He secured for La Crosse the establishment of a health department with a first full time medical officer.

At the time of the World War, Dr. Evans was chairman of Wisconsin Committee for classification of hospitals and physicians; medical member of the State and County Council of Defense; Chairman of the District Advisory Draft Board; Red Cross surgeon and Major in France in 1918.

He was a former foreign medical representative of McGill University; former regent of the University of Wisconsin from 1902 to 1913, and a former member of the Board of Education of La Crosse and a member of the Library Board of that city. For twenty-two years he served as councilor, and twelve years as Chairman of the Council of the State Society and in 1909 was President of the State Medical Society.

Dr. Evans was the original sponsor of the University of Wisconsin Extension Division's educational plan to hold clinics in different sections of the State. At the time of his death, he was a director of the Wisconsin Anti-Tuberculosis Association, a position he had held for more than twenty years.

Dr. Evans was deeply interested in the University of Wisconsin Medical School from its beginning. He was active in the extension of the school with the four-year course and was deeply interested in the preceptor plan being the Chief of Preceptors at St. Francis Hospital.

In January, 1931, he was made an honorary member of the La Crosse County Medical Society, the State Medical Society and the American Medical Association. He was also a member of the Western Surgical Association and American College of Surgeons. In the same year he was given the Council award for outstanding service.

Dr. Evans had six children, four sons and two daughters. Five survive him, the eldest daughter, Mrs. Mary Francis Evans Leary preceded him in death nine years ago.

Dr. Guerdon C. Buck, Platteville, died on June 20th of a heart attack.

Dr. Buck was born in Platteville in the year 1873. He was a graduate of Platteville State Teachers' College, the University of Wisconsin, and Cornell University Medical College in 1900. He was a member of the Tripoli shrine, Milwaukee.

The deceased was a member of Grant County Medical Society, the State Medical Society, and was a fellow of the American Medical Association.

He is survived by his widow, his mother and five sisters.

Dr. Emil Christensen, Two Rivers, died suddenly at his home on May 26th of apoplexy.

Born in Christiana, Norway, June 12, 1870, Dr. Christensen immigrated to this country with his parents and settled in Bellfield, N. Dak. He graduated from Wisconsin College of Physicians and Surgeons, Milwaukee, in 1896 and then practiced in Chicago for a year. Thirty-four years ago, Dr. Christensen came to Two Rivers and became associated with the late Dr. J. R. Currens, a former president of the State Society. After eighteen years of partnership, Dr. Christensen practiced independently.

He was at one time president of Manitowoc County Medical Society and served as county coroner, city physician and health officer of Two Rivers.

He was a member of Manitowoc County Medical Society, the State Medical Society and was a fellow of the American Medical Association.

He is survived by his widow, four sons and one daughter.

Dr. Edward B. Felter, Plymouth, died of pneumonia on June 8th at the Plymouth hospital.

Dr. Felter was born in Fond du Lac, November 18, 1863. He studied pharmacy at the Chicago College of Pharmacy, graduating and becoming a licensed pharmacist. He later studied medicine, graduating from Rush Medical College in 1891, and then established his practice in Plymouth.

Dr. Felter was a past president of the Sheboygan County Medical Society and was a member of the State Medical Society and a fellow of the American Medical Association.

Dr. G. H. Robbins, Madison, died on May 26th at his home. He had been in ill health for some time and had just returned to Madison after a month in Texas for his health.

He was born in Milwaukee on August 20, 1890. He was a graduate of the University of Wisconsin and of Rush Medical College in 1915. In 1920 he became associated with the Dean Clinic but for the past five years had been associated with his brother Dr. Holden J. Robbins, Madison. Dr. Robbins was at one time a lecturer in clinical medicine at the University of Wisconsin Medical School. During the World War, he served as first lieutenant in the medical corps.

Dr. Robbins was a member of the Dane County Medical Society, the State Medical Society and was a fellow of the American Medical Association.

He is survived by his widow, one son and two daughters.

Dr. Stephen S. Stack, Milwaukee, died at Sacred Heart Sanitarium on June 18th after an illness of more than a year.

He was born in Fond du Lac County. After his graduation from Rush Medical College in 1883, he spent some years in study abroad. He returned to

Fond du Lac to practice medicine and came to Milwaukee to join the staff of Sacred Heart Sanitarium and for the past thirty years has been medical director of that institution. He retired from active service a year ago.

Dr. Stack was a member of the Medical Society of Milwaukee County, the State Medical Society, and was a fellow of the American Medical Association. He was also a member of the American Psychiatric Association.

He is survived by two sons.

Dr. H. E. Johnston, Oshkosh, died on May 22nd at the home of a cousin in Edwardsburg, Michigan.

He was born in the year 1864 and was a graduate of Chicago Homeopathic Medical College in 1893. He had practiced medicine in Oshkosh for the past thirty-seven years.

He was at one time president of the Wisconsin Homeopathic Society and was a member of the Winnebago County Medical Society, the State Medical Society and the American Medical Association.

Dr. Myron G. Rood, Stevens Point, died at his home after a long illness.

He was born in Stevens Point, Dec. 14, 1858, and was a graduate of the Medical College of Ohio in 1882. He had practiced medicine in Stevens Point since his graduation, and retired fifteen years ago.

He is survived by one sister.

Dr. Albert M. Benson, Hartford, died on June 9th.

Dr. Benson was born in 1856 and was a graduate of Hahnemann Medical College, Chicago, in 1881. Dr. Benson was active in humane work in the state and was editor of the Humane Herald.

SOCIETY RECORDS

New Members

M. E. J. Wiese, 606 W. Wisconsin Ave., Milwaukee.

R. O. Settle, Waupun.

S. A. Freitag, 500 W. Milwaukee St., Janesville.

F. M. Frechette, 500 W. Milwaukee St., Janesville.

Arno H. Fromm, 2200 N. Third St., Milwaukee.

Anthony S. Kult, 1501 W. Cherry St., Milwaukee.

I. B. Reifenrath, 2650 W. Hopkins St., Milwaukee.

Joseph P. Skibba, Kaukauna.

James J. King, 212 W. Wisconsin Ave., Milwaukee.

Wallace Nelson, Wisconsin Rapids.

Changes in Address

H. M. Lynch, Milwaukee to 147 North Main St., West Bend.

Helen Binnie, Hawesville, Ky., to 7609—25th Ave., Kenosha.

V. B. Mauricau, Stanley to 907 Peoria Life Bldg., Peoria, Ill.

» » » CORRESPONDENCE « « «

To the Officers and Council,
State Medical Society of Wisconsin.

Words are inadequate to express our deep appreciation of the lovely spray of roses sent in memory of Doctor Evans—nor can we forget the bouquet of snapdragons sent him at the hospital which brought such joy to his heart, for he knew his friends had not forgotten him.

Gratefully yours,
MRS. EDWARD EVANS AND FAMILY.

"STEAM ROLLER ELECTIONS"

Portage, Wisconsin, May 27, 1932.

To the Editor,
Wisconsin Medical Journal:

Our State Medical Society seems to be officered and controlled largely by state employes. Daily we notice state encroachments in our private domains.

County nurses are made a part of our necessary paraphernalia. These nurses quickly become state agents through the influence of the State Health Department and the University.

The chest clinics are becoming part of the public's entertainment and heap upon the doctors' desks huge bundles of reports of free chest examinations of our patients with notes of instructions to feed this one ham and eggs and that one pork and beans. Some of our healthiest and wealthiest citizens go for a free chest examination purely for amusement.

University Extension work is carried on extensively throughout the state. All these activities, doubtless, do some good, but it is quite probable that the antagonism created in the medical profession overbalances any good done.

The state does not seem to find it necessary to give the dental profession or the legal profession all this attention and why should the medical profession need so much supervision and help?

Is it because the medical profession is so deplorably weak, and have the poor people been so sadly neglected by the counties that the state finds it necessary to step in?

Thousands of beds in the hospitals throughout the state are empty and the hospitals exerting every effort to maintain existence. Thousands of doctors throughout the state are caring for the people in their communities who, heretofore, have been able to pay but at present are not. Thousands of indigent sick who, heretofore, were cared for in the local hospitals by the counties are now sent to the State Hospital at nearly three times the expense to the counties. Last year $286,367.10 was paid by the

counties to the state but the state contends that it is unreasonable for the counties to spend this money in their own communities for the same purpose that they pay it to the state.

If it is necessary to comb the state of Wisconsin, depriving hospitals and physicians of their just clientele in order to maintain a medical school in the University, then I maintain that a medical school should not exist there. I have always felt that a 4-year medical department at Wisconsin University was ill advised and not necessary. Better medical schools are in existence and accessible to any one desiring to take up the profession and I feel that very few doctors would advise any medical aspirant to be content with anything but the best, and the best can never exist in a small town, because of the lack of clinical material.

The aim of our Society for its membership should be capability and efficiency. That is not acquired by state sponsorship but by honest competition. State or University employes are not living our lives, earning our bread or fighting our battles. I do not wish to attempt to create a division between the two groups but I do say that the State Medical Society of Wisconsin should run its own affairs for the benefit of the majority of its membership and should allow no "steam roller" elections of its officers. It should have its lobbyists to take care of such legislation as may affect the membership of the Society in a way which will protect the members. We are not interested in building up huge state institutions which are a tax burden to the people and a detriment to the medical profession and a detriment to the care of deserving poor sick through abuses of privileges at such institutions.

I believe it is the duty of every county society to instruct its delegates to elect such officers as will represent our State Society and not the University or State and also vote for such other measures that may be presented which will protect and benefit the membership of this Society. Any member of the Society who is not willing to vote for and work for the above principles is, doubtless, influenced by some personal ambition quite remote from the general welfare of the State Medical Society of Wisconsin.

Article II of our Constitution states that the "purpose of the State Medical Society of Wisconsin shall be to guard and foster the material interests of its members and to protect them against imposition". That means imposition by state institutions as well as private individuals.

An editorial in the November issue of our Journal elaborates on periodic health examinations and calls their neglect "Costly Mistakes" of physicians. When the public is daily being educated by insurance companies and other associations to receive free health examinations, it is not surprising that people will not heed the doctor's advice to have periodic examinations because they know that there will be a charge for such service. If the public demands it and the medical profession can show that it is a wise procedure it might be possible to get the Legislature to make an appropriation for that purpose. Appropriations have been made for much less important projects.

Let's charge these "Costly Mistakes" up to a negligent legislative activity within our own ranks, also such other costly mistakes as have been made in our state affecting seriously the members of the Medical Society of Wisconsin who are engaged in private practice.

I am mentioning all this to emphasize the importance of county medical societies sending their delegates to the annual meeting, instructed to vote only for such measures and nominees for office as will "guard and foster the material interests" of the members of this Society and "protect them against impositions."

ARTHUR J. BATTY.

"NURSES IN INDUSTRY"

NATIONAL SAFETY COUNCIL

Chicago, May 25, 1932.

Mr. J. G. Crownhart, Secretary,
Wisconsin Medical Society,
119 East Washington Avenue,
Madison, Wisconsin.

Dear Mr. Crownhart:

Several industrial nurses have recently called my attention to what is known as Standing Orders for Industrial Nurses as published by the Wisconsin Medical Society. It is my understanding that these orders are to be adopted by the industrial medical services in different plants, providing the individual physicians who have charge of the service are agreeable.

As a national organization which is in contact with over five thousand different industrial groups, the National Safety Council is naturally interested in such procedures. We are particularly interested, of course, because of the fact that we have what is known as the Industrial Health Division which renders advice and counsel on industrial health problems and the common problems of industrial safety and health.

If it is possible, therefore, I shall appreciate your sending me a copy of the manuscript of Standing Orders for Industrial Nurses. In my own experience, I have known of several medical directors who have used such orders, adapted to their own experience and their manufacturing groups.

Yours truly,
C. O. SAPPINGTON, M. D.,
Director, Division of Industrial Health.

DEATH OF DR. K. W. DOEGE

As the Journal goes to press, we learn of the death of Dr. K. W. Doege of the Marshfield Clinic, past president of the State Medical Society of Wisconsin at Marshfield on Tuesday, June 28th. The immediate cause of death was coronary thrombosis.

Members Urged to Fill in Questionnaire by Special Committee on Investigation of Admittance to State Hospital

While upwards of eight hundred questionnaires have already been returned to the Special Committee on investigation of admittances to the Wisconsin General Hospital, Madison, the Committee at a session on June 17th asked that every member take particular pains to return his questionniare not later than July 15th.

"The Committee now has sufficient data as relates to those questions covering the field of the amounts of charity work extended by individual practitioners," declared Dr. Reginald Jackson, Madison, chairman of the Committee. "We appreciate that some have hesitated to return their questionnaires with these questions unanswered and that there was some difficulty in filling out those particular questions which required rather careful office accounts.

"We are hopeful that every member will return his questionnaire and he need not hesitate to leave any question unanswered in event that he has any difficulty with it. We have secured a large amount of very helpful suggestions and data but we are exceedingly anxious having a more complete return that the Committee's conclusions may represent the great group of the general membership."

Titles of Papers Announced for 91st Anniversary Meeting at Milwaukee, September 14, 15 and 16; Dean Scammon to Address Dinner

Sixty-seven papers will be presented before the 91st anniversary meeting of the State Society to be held in Milwaukee, September 14–16, according to Dr. T. L. Squier, chairman of the Committee on Scientific Work. In addition to presentation before the formal sessions of the Society, twelve round table meetings will be held on Thursday noon and the general sessions Wednesday morning will be preceded by clinics in Milwaukee hospitals for the first two and a half hours. Dr. Squier announces that Dr. Richard E. Scammon, Dean of Medical Sciences, University of Minnesota will be the speaker of the evening at the annual dinner on September 15th. Those who will address the several sessions of the Society with their subjects follow:

1. Injuries to the Heart and Aorta.
   Dr. L. M. Warfield, Milwaukee.
2. Leukopenia and Acute Leukemias with the Differential Diagnosis from Similar Blood Conditions.
   Dr. Charles H. Watkins, Rochester, Minn.
3. Etiology and Pathology of Renal Infections.
   Dr. W. J. Carson, Milwaukee.
4. The Orthopedic Treatment of Infantile Paralysis.
   Dr. Walter P. Blount, Milwaukee.
5. Nephritis.
   Dr. E. T. Bell, Minneapolis.
6. Dermatology in General Practice.
   Dr. L. M. Wieder, Milwaukee.
7. Clinical Aspects of Bright's Disease.
   Dr. Francis D. Murphy, Milwaukee.
8. The Leukopenic Syndrome.
   Dr. Fred Madison, Milwaukee.
9. Surgical Treatment of Hand Injuries.
   Dr. T. S. O'Malley, Milwaukee.
10. Bronchoscopic Examination as an Aid in Obscure Pulmonary Conditions.
    Dr. John S. Gordon, Milwaukee.
11. The Dawn of a New Specialty in Medicine—Allergy.
    Dr. W. W. Duke, Kansas City.
12. The Clinical Significance of Recent Advances in Medical Science.
    Dr. Wm. D. Stovall, Madison.
13. Treatment of Morphinism.
    Dr. Merle Q. Howard, Wauwatosa.
14.
    Dr. Julius Bauer, Vienna.
15. Differential Diagnosis and Treatment of Common Bowel Disturbances. Lantern Slides.
    Dr. R. C. Blankinship, Madison.
16. Cretinism and Hypothyroidism.
    Dr. Charles H. Stoddard, Milwaukee.
17. Treatment of Osteomyelitis. Lantern Slides.
    Dr. Walter J. Jones, Fond du Lac.
18. Tuberculosis Studies in the "Teen Age" Groups.
    Dr. A. A. Pleyte, Milwaukee.
19. The Development of Medical Education in the United States.
    Dr. C. R. Bardeen, Madison.
20. Clinical Study of Vitamin D Milk.
    Drs. N. E. McBeath and H. O. McMahon, Milwaukee.
21. Oration in Medicine. The Parathyroid Glands and Their Relationship to Calcium Metabolism.
    Dr. David Barr, St. Louis.

22. Keeping the Worker Well and Keeping the Practice of Medicine in the Hands of the Medical Profession.
    Dr. C. F. Schram, Beloit.
23. The Ambulatory Treatment of Hemorrhoids. Analysis of over Twelve Hundred Cases.
    Dr. J. M. Scantleton, Sparta.
24. The Female Sex Hormone.
    Dr. Elmer L. Sevringhaus, Madison.
25. Intussusception.
    Dr. L. W. Peterson, Shawano.
26. The Clinical and Pathological Aspects of the Cancer Problem.
    Dr. Max Cutler, Chicago. Director Tumor Clinic, Michael Reese Hospital.
27. Oration in Surgery.
    Dr. Geo. W. Crile, Cleveland.
28. Otitis Media and the Family Physician.
    Dr. John P. Harkins, Madison.
29. The Treatment of Heart Disease.
    Dr. Ellsworth S. Smith, St. Louis, Mo.
30. Treatment of Burns.
    Dr. Stanley Seeger, Milwaukee.
31. Asbestosis.
    Dr. Ralph G. Mills, Fond du Lac.
32. Upper Respiratory Infections in Children.
    Dr. G. H. Fellman, Milwaukee.
33. The Suitable Time for Surgery in Children.
    Dr. Irwin Schulz, Milwaukee.
34. Indications and Contraindications for Biopsy in Surgery.
    Dr. P. F. Doege, Marshfield.
35. Malignant Conditions of Lung.
    Dr. Wm. Jermain, Milwaukee.
36. Obstetrical Analgesia.
    Dr. R. H. Ludden, Viroqua.
37. Electrocardiogram in General Medicine.
    Dr. Benjamin J. Birk, Milwaukee.
38. The Use of the Colloidal Phase in Urine for Diagnostic Purposes.
    Dr. Fredrick Eigenberger, Sheboygan.
39. The Physician of Yesterday, Today and Tomorrow.
    Dr. John F. Bennett, Burlington.
40. Nasal Polyps with Radium after Removal.
    Dr. Walter A. Ford, Sheboygan.
41. Some Unusual Duodenal Pathology.
    Dr. James A. Evans, La Crosse.
42. Differentiation of Bronchial Asthma from the Paroxysmal Dyspnea of Cardiac Origin.
    Dr. Herbert P. Benn, Stevens Point.
43. Treatment of Intestinal Obstruction. Involving Problems in Abnormal Physiology and Chemistry.
    Dr. Edmund H. Mensing, Milwaukee.
44. Addison's Disease.
    Dr. R. B. Montgomery, La Valle.
45. The Management of Orbital Abscess Following Sinus Infection.
    Dr. John B. Hitz, Milwaukee.
46. Prevertebral Abscesses. Case Report with Lantern Slides.
    Dr. F. C. Christensen, Racine.
47. Roentgen Ray Exploration of Pelvic Viscera with the Aid of Brominized Oil. Lantern Slides.
    Dr. Joseph J. Eisenberg, Milwaukee.
48. Diaphragmatic Hernia.
    Dr. Robert Blumenthal, Milwaukee.
49. The Chronic Infected Prostate.
    Dr. Cyril G. Richards, Kenosha.
50. Anal Fissures.
    Dr. A. C. Gorder, Milwaukee.
51. Acute Abdominal Surgery from the Standpoint of the General Practitioner.
    Dr. L. O. Simenstad, Osceola.
52. A Roentgenological Evaluation of Nervous Indigestion.
    Dr. F. H. Kuegle, Janesville.
53. Measles Encephalitis
    Dr. Max J. Fox, Milwaukee.
    Discussion, Dr. J. L. Garvey, Milwaukee.
54. Relative Position of Radiologist and the Medical Profession.
    Drs. L. V. Littig, J. N. Sisk, and E. A. Pohle, Madison.
55. Differential Diagnosis of Hyperthyroidism and Neuroses.
    Dr. A. L. Mayfield, Kenosha.
56. Observations on Some Abdominal Conditions in Childhood.
    Dr. Samuel Amberg, Rochester, Minn.
57. Congenital Syphilis.
    Dr. R. P. Schowalter, Milwaukee.
58. Acute Anterior Poliomyelitis; A Pediatric Problem.
    Dr. F. R. Janney, Milwaukee.
59. Interpretation of Roentgenograms of the Skull in Children.
    Dr. Helen J. Zillmer, Milwaukee.
60. Convulsion in Children. Lantern Slides and Moving Pictures.
    Dr. M. G. Peterman, Milwaukee.
61. Roentgen Therapy in Giant-Cell Tumor of Bone (With Cases).
    Dr. Barton W. Johnson, Fond du Lac.
62. Glioma of the Retina. Lantern Slides.
    Dr. Richard C. Smith, Superior.
63. The Effect on the Lungs of Fungus Spores Found in Maple Bark.
    Dr. J. W. Towey, Powers, Mich.
64. The Foundation and Early History of St. Mathalamews—The First Hospital in London.
    Dr. Richard E. Scammon, Minneapolis.
65. Roentgenology in the Diagnosis of Thoracic Lesions.
    Dr. R. P. Potter, Marshfield.
66. Gall Bladder Disease.
    Dr. Arnold Jackson, Madison.
67. Blood Grouping.
    Dr. Arthur A. Schaefer, Milwaukee.

ROUND TABLES

Round table luncheons on Thursday noon will again be by registration to limit each

group to twenty. The preliminary announcement lists the following sessions:

1. Surgical Subject to be announced.
   O. R. Lillie.
2. Subject to be announced.
   Stanley Seeger—Surgical.
3. Fractures of the Foot and Ankle.
   F. J. Gaenslen.
4. Vasomotor or Hyperesthetic Rhinitis.
   W. E. Grove.
5. Subject to be announced.
   James C. Sargent—Urology.
6. Surgery of Pulmonary Tuberculosis.
   J. L. Yates.
7. Gall Bladder Symposium.
   H. B. Podlasky.
8. Subject to be announced.
   Jos. Lettenberger—Medical.
9. Subject to be announced.
   W. J. Egan—Medical.
10. Chronic Infections of the Lung in Childhood.
    Karl Kassowitz—Pediatrics.
11. Subject to be announced.
    Carl Henry Davis—Obstetrics.
12. Diseases of Chest.
    Oscar Lotz.

WOMAN'S AUXILIARY

The wives of all Wisconsin physicians are cordially invited to attend the entertainment planned in their honor by the Woman's Auxiliary. The Auxiliary proper will have a Board meeting of its officers on Tuesday evening with a business session to be announced. Special entertainment is planned for both Wednesday and Thursday afternoons and the Auxiliary is to be honored with Mrs. Walter Jackson Freeman of Philadelphia, president of the National Auxiliary and Mrs. James Blake of Hopkins, Minnesota, president-elect. Entertainment for the ladies will continue through Thursday ending with the annual dinner on Thursday evening, following which there will be dancing and cards.

GOLF TOURNAMENT PLANS

Dr. Francis A. Thompson, President of the Milwaukee County Golf Association, has been selected as chairman of the committee in charge of the State Society's annual golf tournament. Dr. Thompson announces that as in former years the tournament will be held on the first day, Tuesday, September 13th.

The Committee has engaged the Tripoli Country Club course which will also be available for individual play following the tournament during the three days of the meeting.

Prizes, topped by the President's and Secretary's cups, will be offered for the tournament play. The Committee has featured plans for a real get-together of the physician golfers and its complete program will be announced in the August issue of the Journal.

HOUSE OF DELEGATES

At this meeting the terms of the following councilors expire: Dr. Spencer D. Beebe, Sparta, seventh district; Dr. T. J. Redelings, Marinette, eighth district; Dr. Joseph F. Smith, Wausau, ninth district; and Dr. H. M. Stang, Eau Claire, tenth district. The House will also be called upon to elect the following officers: a President-Elect; a Speaker of the House to succeed Dr. Stanley J. Seeger, Milwaukee; a Vice-Speaker to succeed Dr. M. D. Bird of Marinette; delegates to the American Medical Association to succeed Dr. J. Gurney Taylor, Milwaukee, and Dr. W. E. Bannen of La Crosse and alternate delegates to succeed Dr. F. Gregory Connell, Oshkosh, and T. W. Nuzum of Janesville.

The Tuesday evening session will receive reports of all of the committees of the Society referring them to reference committees of the House which will report their recommendations at the Wednesday evening session. Councilors and the Committee on Nominations will both be selected at the Tuesday evening session at which time the House will also be called upon to confirm the Committee appointments of President-Elect Reginald Jackson of Madison.

The House has pending before it an amendment to the Constitution introduced by Dr. Spencer D. Beebe a year ago, to provide that councilors, like past presidents of the Society, are to be ex-officio members of the House without the right to vote.

The Tuesday evening session at which the House will receive the report of the special

committee on distribution of medical services will be an executive session. Members of the Society not delegates or alternates will be admitted to the meeting, however, upon proper identification.

TECHNICAL EXHIBITS

Sixteen of the seventeen booths available have been reserved by technical exhibitors for the 91st anniversary meeting. The exhibits will occupy the hall opposite and adjacent to that in which the scientific sessions will be held. Among those who will exhibit at this meeting are:

Booth No.	*Exhibitor*
1	Medical Protective Company
2	Mead Johnson & Company
3	Mellin's Food Company
4	Victor Mueller Company
5	Scanlan-Morris Mfg. Company
6	E. H. Karrer Company
7	Roemer Drug Company
8	W. B. Saunders Company
9	Horlick's Malted Milk Corporation
10	H. G. Fischer & Co. Inc.
11	Kremers-Urban Company
12	
13	Merck & Company
14	Victor Hurley Company
15	DeVilbiss Company
16	General Foods Corporation
17	General Electric X-Ray Corporation

Dr. Bardeen Honored on Twenty-fifth Anniversary as Dean of University of Wisconsin Medical School

Culminating in the presentation of a portrait of Dr. Charles R. Bardeen, twenty-five years Dean of the University of Wisconsin Medical School, three hundred physicians of Wisconsin and neighboring states and friends of the Dean gathered at a banquet at the Memorial Union building at Madison on June 21st to pay tribute to his long years of service. Dr. Bardeen was described by President Glenn Frank as "a great scientist, teacher, singularly expert administrator, and an altogether lovable human being and colleague with whom it is an unalloyed pleasure to work."

The program of the evening took occasion to review the history of Wisconsin's medical center. President Emeritus E. A. Birge described the early work at the University and its early courses which led to the establishment of the formal pre-medical school in 1907.

Dr. Howard L. Beye, University of Iowa, one of the students in the first class to graduate from the pre-medical course, paid tribute to Dr. Bardeen for the excellence of the course that had given the fundamental work to so many prominent physicians through the country.

Dr. Elias P. Lyon, Dean of the University of Minnesota Medical School, presented the subject of complex work of the Dean of the Medical School and at the conclusion of his address, Dr. H. C. Bradley, Madison, presented the portrait which was accepted for the institution by President Frank.

Dr. Charles R. Bardeen

In response to the many tributes, Dr. Bardeen declared that he was receiving but the reflected glory of the work of others who had assisted him, and discussed in some detail the various periods in his work at Wisconsin. In concluding his address, Dr. Bardeen warned of the danger that was

Have You Answered Your Questionnaire?

THE Committee on Investigation of Admissions to the Wisconsin General Hospital (now enlarged to number 11 members) is preparing a brief of the various points involved in its investigations. It desires, before completing the tabulation of replies to certain of the questions asked, to give every member a final chance to go on record as to his position. Analysis of the replies received to date are as follows:

	Yes	No
Question No. 1	18%	82%
Question No. 2	79%	21%
Question No. 3	85%	15%
Question No. 4	92%	8%
Question No. 5	90%	10%

The Committee has received sufficient data on the amount of unremunerated service rendered society by our membership in an average year. Therefore, please omit answers to questions asked on this subject. It will not take you over one-half hour to answer questions 1 to 5, and such others as you choose to. Leave out all those that require bookkeeping figures.

Signed THE COMMITTEE,

GUNNAR GUNDERSEN, La Crosse
STEPHEN GAVIN, Fond du Lac
FRANK POPE, Racine
JOHN YATES, Milwaukee
CARL DAVIS, Milwaukee
DREXEL DAWSON, Rice Lake
THOMAS O'LEARY, Superior
GREGORY CONNELL, Oshkosh
ROCK SLEYSTER, Wauwatosa
JOSEPH DEAN, Madison
R. H. JACKSON, *Chairman,* Madison.

peculiarly present in such times as these in commercializing the profession of medicine by referring to the emblems that are sometimes used as representative of the profession.

"There are two emblems used by American physicians," said Dr. Bardeen. "One represents Aesculapius, the god of healing and the father of Hygeia, goddess of health, the other Hermes, the god of Commerce.

"One hates to see Aesculapius himself in danger of infection from Hermes. The disciples of Aesculapius are more interested in the patient than in income and with a kindly smile treat rich and poor alike. The disciples of Hermes are more interested in income than in the patient and aim at all the traffic will bear."

Among those present at the dinner were representatives of all the preceptorial staffs, Dean J. T. McClintick of the University of Iowa; Dean J. H. J. Upham of Ohio State University; Dean Irving S. Cutter, Northwestern University; Dean David J. Davis, University of Illinois; Dean Richard E. Scammon, University of Minnesota; Dr. N. P. Colwell, secretary emeritus of the Council on Medical Education of the American Medical Association; Dr. John F. Kuhn, representing the University of Oklahoma, and a large number of former students. Telegrams from prominent physicians throughout the country were read during the course of the evening.

Attorney General Holds Chiropractic Treatment Restricted to Manipulations; Electrotherapy Illegal

In a long opinion addressed to James R. Durfee, district attorney of Langlade County, Antigo, Fred M. Wylie, deputy attorney general of Wisconsin, holds that chiropractic as licensed in Wisconsin is confined to manipulations of the articulation of the human body and that one licensed only as a chiropractor may not use electrotherapy without becoming subject to prosecution and violation of the medical practice act. The opinion of the Attorney General follows:

June 16, 1932.

James R. Durfee,
District Attorney,
Langlade County,
Antigo, Wisconsin.
Dear Sir:

You state that a chiropractor is making use of electrotherapy machines in the conduct of his business.

You ask for a discussion of the latitude of chiropractic and also, if the chiropractor is violating the law, under what statute he should be prosecuted.

Chiropractic was first recognized by the Wisconsin legislature in 1915, when it enacted section 1435 (e), reading:

"Reputable practitioners of chiropractic may practice their profession in this state, provided that they do not represent themselves to be or hold themselves out as registered or licensed; and provided further, that there is conspicuously displayed in the offices or places where they practice their profession a sign or signs containing the following words in large and legible type: 'Not registered or licensed in Wisconsin.' "

In 1925 the legislature first made provision for the licensing of chiropractors, by the enactment of section 147.23 of the statutes. The statute did not attempt to define what chiropractic was, but merely provided that "no person shall practice chiropractic" unless licensed as therein provided. Subsec. (4) provided that the examination "shall be in the subjects usually taught in such reputable schools of chiropractic." In the absence of a definition in the statute, the word "chiropractic" must have whatever meaning it had at the time of the enactment of the statute, subject, of course, to improvements in the system, but not to the adoption of another system fundamnetally different. So our inquiry at once turns to an investigation of what chiropractic was in 1925.

A number of states had chiropractic regulation at that time. Many of them had defined the word. An examination of those definitions will be of help.

Arkansas: "Said license * * * shall entitle the holder thereof to adjust by hand the displaced segments of the vertebral column and any displaced tissue in any manner related thereto."

Kansas: "Any chiropractor * * * may adjust by hand any displaced tissue of any kind or nature."

North Dakota: "Any chiropractor * * * may adjust any displaced tissue of any kind or nature."

Colorado: "The practice of chiropractic as used in this act is hereby defined to mean the treatment of disease or morbid conditions of human beings by palpation, nerve tracing and adjustment of vertebrae by hand."

Connecticut: "The practice of chiropractic shall be understood to be adjustment by hand of any or all of the articulations of the human vertebral column."

North Carolina: "Chiropractic is hereby defined to be the science of adjusting the cause of disease

by realigning the twenty-four movable vertebrae of the spine, releasing pressure on nerves radiating from the spine to all parts of the body, and allowing the nerves to carry their full quota of health current (nerve energy) from the brain to all parts of the body."

Idaho: "Any licentiate * * * may adjust any displaced segment of the vertebral column or any tissue related thereto for the purpose of removing occlusion of nerve stimulus in the bodies of human beings."

Florida: "Any chiropractor * * * may adjust by hand any displaced tissue or any kind or nature or otherwise practice according to the tenets of his or her respective school."

Minnesota: "Chiropractic is hereby defined as being the science of adjusting any abnormal articulations of the human body, especially those of the spinal column, for the purpose of giving freedom of action to impinged nerves."

Montana: "Chiropractic is the science that teaches that disease results from anatomic disrelation and teaches the art of restoring anatomic relation by a process of adjusting by the use of the hand. No other means of securing health shall be construed to be chiropractic except the application of the inherent qualities at the time in the patient or appertaining to the chiropractor."

Nebraska: "Any person shall be regarded as practicing chiropractic within the meaning of this article who shall adjust by hand any articulation of the spine."

Washington: "Any chiropractor * * * may adjust by hand any articulation of the spine."

Maryland: "Any chiropractor * * * may adjust by hand any articulation of the spinal column."

New Jersey: "The term chiropractic * * * shall be construed to mean and be the name given to the study and application of a universal philosophy of biology, theology, theosophy, health, disease, death, the science of the cause of disease and art of permitting the restoration of the triune relationships between all attributes necessary to normal composite forms, to harmonious quantities and qualities by placing in juxtaposition the abnormal concrete positions of definite mechanical portions with each other by hand, thus correcting all subluxations of the articulations of the spinal column * * *."

Arizona: "Any chiropractor * * * may adjust by hand any articulations of the spinal column."

Georgia: "Chiropractors * * * shall have the right to adjust patients in Georgia, according to specific chiropractic methods."

Iowa: "The practice of chiropractic shall be deemed to be the adjustment by hand of the articulations of the spine and other incidental adjustments according to chiropractic methods."

New Hampshire: "Chiropractic is herein defined to be the science of adjusting the cause of disease by realigning by hand the twenty-four movable vertebrae of the spinal column or misalignments of the sacro-iliac articulations."

Oklahoma: "Chiropractic is hereby defined to be the science that teaches health in anatomic relation and disease or abnormality in anatomic disrelations, and includes hygiene and sanitary measures incident thereto."

South Dakota: "Chiropractic is hereby defined to be the adjustment by hand of the articulations of the human spine."

Tennessee: "Chiropractic is defined as the science of palpating, analyzing and adjusting the articulations of the human spinal column by hand."

Utah: "The science of palpating and adjusting the articulations of the spinal column by the hands only."

Note that in all of the foregoing definitions, the keynote is *adjustment;* that in practically all of them, the adjustment is *by hand;* and that in practically all of them, the adjustment is of the spinal column.

In New Mexico, the definition covers treatment of physical or mental conditions, by the use of methods such as palpating, diagnosing, adjusting and treating by the application of manipulative, manual and mechanical means, including all natural agencies imbued with the healing art, such as food, water, heat, cold, electricity, vacuum cupping and drugless appliances, without the use of drugs or what are commonly known as medicinal preparations, or in any manner severing or penetrating any of the tissues of the human body known as surgery.

Maine defines chiropractic as "it is taught and practiced by the recognized schools and colleges of chiropractic."

Vermont does not define the word, nor does it expressly limit the chiropractor's activities.

Except as to the last state, all states expressly prohibit the use of drugs and the practice of surgery, and some go even further in expressly inhibiting the inclusion of forms of treating the sick other than by chiropractic manipulation.

Since 1925, other states have enacted laws relating to chiropractic, and these carry out the points brought out above, namely, that chiropractic is *adjustment, by the hand,* generally confined to the *spinal column,* and that *medicines and surgery* are prohibited.

See statutes of: Kentucky, Missouri, Rhode Island, West Virginia, Wyoming.

What definition do the organized Wisconsin chiropractors themselves give? They say:

"Chiropractic is a philosophy, science and art of thing natural; a system of *adjusting* the articulations of the *spinal column, by hand* only, for the correction of the cause of disease. This definition is inclusive and any and all other methods are declared not to be chiropractic. All else belongs to other methods." See advertisement of 20th convention of the Wisconsin Chiropractic Association, Appleton Post-Crescent of October 6, 1931.

In 1923 the chiropractors had a bill introduced in the legislature which authorized chiropractors to be licensed "to adjust by hand displacements of the human vertebral column." (The bill was defeated.)

(Continued on page 492)

PRESS SERVICE OF STATE MEDICAL SOCIETY

No serum does so much for public health as printer's ink

DIABETES

Madison, Wis., June 2.—It is no longer necessary that a diabetic should be thin or that he should avoid work. Diabetes is now under sufficient control so that a diabetic can be as well nourished as any other person, and can work as hard as he chooses.

This is a part of a statement made public here today by the Educational Committee of the State Medical Society, answering many inquiries as to the use of insulin by diabetics. In the third of a series of articles on this subject the bulletin declares that all foods eaten by diabetics should be carefully measured since the body can make sugar from protein foods.

"The modern standards for the maintenance diets to be given to diabetics take these things into consideration," declares the bulletin. "If weight is not maintained at the normal level for a given height and age, the diet is improperly designed, or the patient needs insulin. If the diabetic is not losing sugar in his urine but is underweight, his diet needs to be raised. This rule applies whether insulin is used or not The only safe way is to employ a measured intake of food at every meal. The measurement is best made with the use of a special food scale to avoid errors. If the diabetic tries to limit his diet by using food in terms of slices and spoonfuls, he is almost sure to use too much since his appetite makes him cheat himself. Cheating is far less apt to happen when the figures of a scale are seen. Any errors with a scale will not be due to opinions as to what is a spoonful or an average-sized slice.

"The good results from the use of a carefully weighed diet routine are so evident that no diabetic ought to try to get along in any other way. If the meals are so planned that the amounts of carbohydrate foods are as small as is known to be safe, with the fats proportionately high, these diets are economical. Such proportioning of fat and starchy foods needs to be done by a physician who is experienced in the management of diabetic patients. Diet plans of this sort are easily available to any Wisconsin doctor. If the diabetic patient is unable to keep free from sugar in the urine while using such a diet, a change needs to be made. If the diet is more than enough to maintain weight, a smaller diet should be tried. If weight is not being maintained, insulin is needed and may be expected to help in the gain of weight and also of greater strength. Insulin is usually not advised if the diabetic is able to keep from sugar loss when he eats enough to maintain his normal weight while at his usual occupation. If such diet cannot be taken without the appearance of sugar in the urine, there should be no delay in starting the use of insulin in addition to the diet. The patient is instructed by his doctor in measuring the food, injecting the insulin hypodermically himself, and also in testing his urine so that he may be sure there is no loss of sugar. This sounds formidable, but after a little experience it takes only a few extra minutes each day, and the tasks are performed as habitually as the teeth are brushed. The precautions for the care of diabetes become merely a routine task rather than a real handicap."

* * *

MEASLES

Madison, Wis., June 9.—Avoid people with measles, was the warning issued by the Educational Committee of the State Medical Society in a bulletin issued today.

Measles has broken out in several cities of the state, and in one community 190 new cases developed in one week. The bulletin points out that measles is one of the most common diseases among children which sometimes leaves lasting effects on the health of the child.

"Measles is not only a highly contagious disease as evidenced by the large number of cases occurring in our communities periodically, but it is also a disease far more dangerous than people are in the habit of supposing," the bulletin issued today declares. "To begin with, it produces an extensive process of inflammation involving the eyes, the nose, the sinuses of the head, which communicate with the nose, the throat, the breathing tubes and the lungs, to say nothing of the skin rash. No disease involving such extensive areas of inflammation can ever be regarded as trivial.

"The importance of measles and the reasons why children should be guarded against it may be found in the so-called complications of the disease, that is, the conditions which arise during its course and because of it. The inflammation in the eyes may leave more or less extensive and permanent impairment of vision. The inflammation of the nose may extend into the ears or the sinuses, producing deafness or lingering sinus disease. Pneumonia not uncommonly follows the irritation in the lungs. There are often enlarged glands in the neck which may require surgery before they will recover.

"The complications just named should in themselves be enough to make measles a disease to be feared. Worse than these, however, is the tendency which measles has of awakening tuberculosis, which may be in a quiescent stage. And, worst of all, measles kills more children in the United States every year than either scarlet fever or diphtheria, both of which are more greatly dreaded. The reason for this greater number of deaths is that measles is so very highly contagious that the total number of measles cases is very much greater than the cases of these other diseases.

"The best protection against measles lies in the avoidance of people, and particularly children, who are sick. The early symptoms of measles which persist for from five to seven days before the rash appears are like those of the common 'cold.' People with 'colds' should be avoided and should quarantine themselves until they have recovered. This is not only because of the resemblance of the 'common cold' to a beginning case of measles but because the 'cold' is in itself a contagious disease and the cause of much needless illness and misery."

* * *

BROKEN BONES

Madison, Wis., June 16.—Broken bones are the cause of more gray hairs to your doctor than smallpox. While use of the x-ray has been of great benefit in setting a fracture, even the x-ray cannot overcome many of the difficulties involved in giving you a useful arm or leg.

"Bone repair at the site of fracture is accomplished by the formation of callous," declares the bulletin of the State Medical Society issued today. "This is at first merely soft tissue. Later salts of lime and magnesium are deposited in it and finally it is converted into true bone thus re-establishing the continuity of the affected bone.

(Continued on page 490)

THE JOURNAL BOOK SHELF

Electrotherapy And The Elements of Light Therapy. By Richard Kovacs, M. D., clinical professor and director of physical therapy, Polyclinic Medical School and Hospital, New York; visiting physiotherapist, Manhattan and Harlem Valley State Hospitals and West Side Hospital; Consulting physiotherapist, Hackensack Hospital and Mary Immaculate Hospital, Jamaica, New York. Price $6.50. Illustrated with 211 engravings. Lea & Febiger, Philadelphia, 1932.

Clinical Roentgen Pathology of Thoracic Lesions. By William H. Meyer, M. D., professor of roentgenology in the New York Post-Graduate Medical School of Columbia University. Director of roentgenology in the New York Post-Graduate Hospital. Illustrated with 183 engravings. Price $6.00 net. Lea & Febiger, Philadelphia.

United States Army X-ray Manual. Authorized by the Surgeon-General of the Army. Second edition, rewritten and edited by Lt. Col. H. C. Pillsbury, M. C., U. S. A., Flexible leatherette, 500 pages, 228 illustrations. Price $5.00 net. Paul B. Hoeber, Inc., 76 Fifth Avenue, New York.

Surgical Pathology of the Female Generative Organs. By Arthur E. Hertzler, M. D., surgeon to the Agnes Hertzler Memorial Hospital, Halstead, Kansas; professor of surgery, University of Kansas. 285 illustrations. J. B. Lippincott Company, Philadelphia.

Nutrition Service in the Field. Child Health Centers: A Survey. A Publication of the White House Conference. Price $2.00. The Century Co., New York.

Modern General Anesthesia: By James G. Poe, M. D., lecturer on general anesthesia in the Medical and Dental Departments of Baylor University; anesthesiologist of Baylor University, Hospital of Dallas; consulting anesthetist to the Shriners' Hospital for Crippled Children, and Parkland Hospital, Dallas, Texas. Second edition, completely revised and enlarged, with 12 illustrations and 2 charts. Price $2.50. F. A. Davis Co., 1914 Cherry Street, Philadelphia, Pa.

Psyllium Seed: The Latest Laxative. By Dr. J. F. Montague medical director, Montague Hospital for intestinal ailments. Late of University and Bellevue Hospital Medical College; fellow American Medical Association; fellow New York Academy of Sciences; fellow New York Pathological Society; sometime fellow New York Academy of Medicine and American College of Surgeons. 20 illustrations. Montague Hospital for Intestinal Ailments, New York City. 1932.

BOOKS RECEIVED FOR REVIEW

Lang's German–English Dictionary. Revised and edited by Milton K. Meyers, M. D., neurologist to the Northern Liberties Hospital; chief of Nerve Clinic, St. Agnes Hospital; consulting neurologist, Jewish Hospital, Philadelphia. Fourth edition enlarged. Price $10.00. P. Blakiston's Son & Co., Inc., 1012 Walnut Street, Philadelphia, Pa.

The Expectant Mother's Handbook. By Frederick C. Irving, A. B., M. D., professor of obstetrics, Harvard Medical School; visiting obstetrician, Boston Lying-in Hospital. With illustrations. Price $1.75. Houghton Mifflin Co., Boston.

The Costs of Medicines. The manufacture and distribution of drugs and medicines in the United States and the Services of Pharmacy in Medical Care. By C. Rufus Rorem, Ph. D., C. P. A., and Robert P. Fischelis, B. S., Phar. D. Price $2.50. University of Chicago Press, Chicago, Ill.

The Healing Cults. A study of sectarian medical practice: its extent, causes and control. By Louis S. Reed, Ph. D. Price $2.00. University of Chicago Press, Chicago, Ill.

Clinical Interpretation of Laboratory Reports. By Albert S. Welch, A. B., M. D., clinical instructor in medicine in the University of Kansas School of Medicine in Kansas City, Kansas; director of the laboratory of the Alfred Benjamin Dispensary, and attending surgeon of St. Joseph's Hospital in Kansas City, Mo. Sixteen illustrations. Price $4.00. P. Blakiston's Son & Co., 1012 Walnut St., Philadelphia.

Pain in the Pleura Pericardium and Peritoneum. By Joseph A. Capps, M. D., professor of clinical medicine, University of Chicago with the collaboration of George H. Coleman, M. D., assistant professor of medicine, Rush Medical College. The Macmillan Company, New York. Price $3.00.

BOOK REVIEWS

Any scientific publication reviewed in this column may be obtained for inspection. Orders for such inspection should be directed to the Medical Library Service, 424 N. Charter Street, Madison, Wis.

Obstetric Education. Report of the subcommittee on obstetric teaching and education, Fred Lyman Adair, M. D., Chairman. White House Conference on Child Health and Protection. Price $3.00. The Century Co., New York.

This volume presents the findings of the Subcommittee on Obstetric Teaching and Education of the Committee on Prenatal Care of the White House Conference. The subjects of undergraduate and graduate education of physicians, nurses, nursing attendants, and midwives, as well as the education of the laity and social workers, have been exhaustively studied by various committees.

The practice of obstetrics in this country is still largely in the hands of the family physician, and therefore to him must we look for any pronounced decrease in the appalling mortality that attends childbirth. Undoubtedly more than one-half of these deaths are preventable. No great improvement can be expected until the teaching of obstetrics in the American medical schools undergoes radical improvement. While the physician in general prac-

THE

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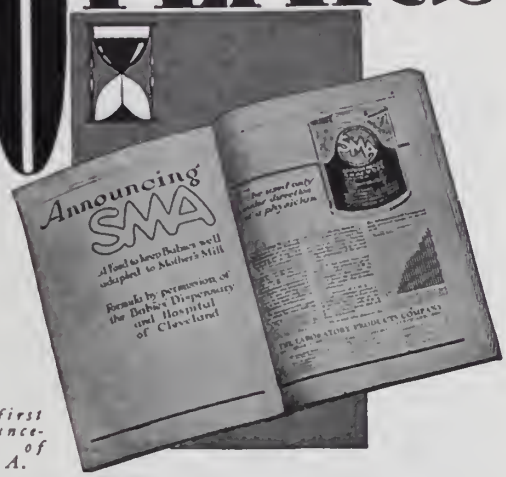

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tice does relatively little surgery as compared to approximately one-third of his time devoted to obstetrics, the time allotted to the teaching of general surgery in American medical schools is from two to four times that given to obstetrics. The difficulty lies not so much in the lack of time for didactic teaching but is due to the woeful lack of teaching material. The problem is all the more serious when it is remembered that only twelve states and thirteen medical schools in this country require a year of interneship preliminary to graduation and licensure. The result is that each year a large number of physicians are precipitated into practice and forced, because of the emergency involved, to manage serious obstetric complications when their training is often so meager that they are scarcely capable of conducting a normal labor.

The Committee recommends that more adequate facilities be provided for the teaching of clinical obstetrics and that more time be allotted in the medical curriculum to the teaching of this subject; that the student should deliver under competent supervision a minimum of twenty-five patients and have the opportunity to witness a larger number of complicated cases; that a rotating interneship of at least one year, embracing a satisfactory maternity service, should be required for licensure to practice medicine.

Both the committees on undergraduate and graduate educations are in entire accord in that the subjects of obstetrics and gynecology should be combined in one department and under one competent head.

The report of the committee on the education of midwives is most interesting. Instead of ignoring the midwife or stating that her profession should be abolished, as is so often done in obstetric circles, the committee shows that she is at present an absolute necessity in certain parts of the country. It is recognized that the ultimate solution of the question will come through making available to the country as a whole the service of physicians adequately trained in obstetrics, but until that happy condition is realized attempts should be made to improve the status of the midwife by education and supervision. Since the problem is local rather than general, it should be faced locally to meet the needs of the community involved.

It seems to the reviewer that the White House Conference could amply justify its existence alone on this most complete study of obstetric education. It is profoundly to be hoped that this volume will be studied carefully by all those interested in medical education, and more especially by the deans of medical schools and others who have the organization and direction of medical education in their hands.

J. W. H.

Surgical Errors and Safeguards. By Max Thorek, M. D., surgeon-in-chief, The American Hospital, Chicago; attending surgeon, Cook County Hospital; corresponding member, Societe Des Chirurgiens De Paris, France; associate Royal Academy of Medicine, Torino, Italy. 668 illustrations. J. B. Lippincott, Company, Philadelphia, Price $10.00.

The book is rather unusual. It deals with difficulties that one meets with in general operative surgery, and what the treatment is. The book covers a large field, is well illustrated, and very nicely done. It makes a very fine book for the man who is doing surgery and wants to get the experience of an older surgeon, in avoiding complications, and in giving the best service to the patient. There are few books written in just this way, to present a certain phase of surgery which is usually not emphasized in the usual text book on surgery. E. R. S.

The Healing Cults. A study of sectarian medical practice: its extent, causes and control. By Louis S. Reed, Ph. D. Price $2.00. University of Chicago Press, Chicago, Illinois.

This is one of the publications of the Committee on the Costs of Medical Care. It deals with Osteopathy, Chiropractic, Naturopathy, and other "Drugless Healing", Christian Science and New Thought Healing, and other types of Faith Healing and concludes with a chapter on the causes of medical sectarianism and legal and non-legal methods of control of medical sects. It is estimated that $125,000,000 is spent annually for the services of the various cults in this country of which $63,000,000 goes to chiropractors, $42,000,000 to osteopaths, $10,000,000 to naturopaths and allied groups, and $10,000,000 to Christian Science and New Thought healers. "All told, the number of these practitioners amounts to almost one-fourth of the number of practicing physicians in this country". The $125,000,000 spent for the services of the former amounts to about 12 per cent of that spent for the services of the latter. The author gives a clear and interesting summary of his subject, a subject of importance not only to every physician but to every layman interested in the public welfare. The Wisconsin basic science law is approved. C. R. B.

Lang's German–English Dictionary. Revised and edited by Milton K. Meyers, M. D., neurologist to the Northern Liberties Hospital; chief of Nerve Clinic, St. Agnes Hospital; consulting neurologist, Jewish Hospital, Philadelphia. Fourth edition enlarged. Price $10.00. P. Blakiston's Son & Co., Inc., 1012 Walnut Street, Philadelphia, Pennsylvania.

The fourth edition of this valuable German–English dictionary of terms used in medicine and the allied sciences is in keeping with the high standards set by previous editions. It is an invaluable aid to all English-speaking people who have occasion to make use of German scientific literature. C. R. B.

Growth and Development of the Child. Part III. Nutrition. Report of the Committee on Growth and Development. Kenneth D. Blackfan, M. D., Chairman. White House Conference on Child Health and Protection, The Century Co., New York. Price $4.00.

This report consists of an accumulation in abbreviated form of the existing knowledge on the prin-

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cipal phases of the subject of nutrition. The phases of nutrition considered are based on the hypothesis that "the term nutrition implies for present purposes, a study of the food substances and of the biochemical process which utilizes them". Twenty-two separate topics are considered and include among them: Appraisal of the National Food Supply, The Protein Requirements of Infants and Children, The Pathology of Vitamin Deficiencies, Iron in Nutrition, Factors Governing the Energy Requirements of Children, Growth and Health in Relation to Nutrition, The Effects of Cooking and Preserving Processes on the Nutritive Value of Food, Psychological Factors in Nutrition. J. E. G.

Pathology for Nurses. By Eugene C. Piette, M. D., pathologist and director of the Clinical Laboratories of the West Suburban Hospital, Oak Park, Illinois: Consultant Pathologist, Chicago State Hospital. With 65 illustrations, some in color. Price $1.75. F. A. Davis Company, 1914 Cherry St., Philadelphia, Pa.

This book is admirably suited for nurses. The subject is handled in a comprehensive and understanding way; yet it is more informative of pathology than of the technique of studying pathology. It is well written and is entertaining as well as informative. The author has organized the material to advance from cause to effect. The causes of disease are discussed briefly and then follows the discussion of the tissue reactions to the various forms of injury.

Although the book contains only two hundred and forty pages, accuracy has not been sacrificed for brevity. W. D. S.

Biochemistry in Internal Medicine. By Max Trumper, PH. D., clinical chemist and toxicologist; formerly in charge of the Laboratories of Biochemistry of the Jefferson Medical College and Hospital and of the Psycho-Biochemistry Laboratory, Graduate School of Medicine, University of Pennsylvania; and Abraham Cantarow, M. D., instructor in medicine, Jefferson Medical College; assistant attending physician, Philadelphia General Hospital; in charge of Laboratory of Biochemistry, Jefferson Hospital. 454 pages with illustrations. Philadelphia and London: W. B. Saunders Company, 1932. Cloth, $5.50 net.

This book is made very valuable by an excellent and detailed index which occupies 44 pages. In addition to discussing laboratory results under the heads of the different types of metabolism, the book takes up groups of pathological processes such as difficulties in a liver, kidney, pancreas, and intestinal function. The critical student will miss the references to the literature by which he could trace the evidence. This would, of course have added greatly to the bulk of the book. The following quotation from the foreword by Dr. E. H. Funk is very fair in the analysis of this book.

"Doctor Trumper and Doctor Cantarow have noted in their experience as teachers in the laboratory and clinic and the difficulty which students and physicians experience in bridging the gap between abstract biochemistry and physiology and clinical medicine. This book is an attempt to bridge the gap and it seems to me the authors have succeeded admirably. By the avoidance of ultrascientific expressions and by the use of easily understandable terms combined with a clarity and directness of statement, the authors have made the reading of the book easy and enjoyable. They have stressed the fundamentals of the subject. They have scrupulously avoided lengthy discussions of laboratory methods and stressed the practical applications of biochemistry of value to the clinician. They have selected for inclusion in the text only those advances in biochemistry which seem to have an important value. They have woven the newer knowledge with the older and established knowledge in such a way as to give an excellent balance to the subject matter of the volume. Observations regarding the normal findings precede discussions of the clinical interpretation of variations from the normal, and by careful cross reference in text and in index needless repetition has been avoided.

"The advancement of our knowledge of the biochemical changes in health and in disease has been most rapid, and many of the conceptions of a few years ago have been completely changed or modified. This book will serve to acquaint the practitioner with the recent advances, many of which are to be found only in special monographs and text books. It will serve as a useful companion volume worthy of position among those other texts which constitute the working library of the medical student and especially the busy practitioner. Doctor Trumper and Doctor Cantarow are to be congratulated for having made a book, the reading of which is destined to stimulate a greater interest on the part of physicians in the broad field of biochemistry as it relates to the clinical study of patients who are ill with many varying diseases." E. L. S.

PRESS SERVICE

(Continued from page 485)

"All this reads like a very simple course of events. This article is warranted only because things do not always proceed as depicted here. The patient may have more than the usual amount of suffering, bones originally in good alignment may later become displaced, it may be impossible to retain them in position, function in adjacent joints may suffer, and paralysis is an ever-present possibility, and finally the bone fragments may unite crooked or not at all.

"If you break a stick of wood you can insert a little glue and put the pieces together again almost perfectly. When a bone is broken the doctor is faced with a difficult task. The muscles tend to pull the broken pieces way out of place. Splinters may have broken completely away from one end or the other. In the presence of these many difficulties and a limb that may be badly swollen from the injury, the doctor is faced with a difficult task.

"It may be said that almost rarely is the most skilled physician able to place the broken bones in the exact place that they were before the break and hold

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them there until the mending is complete. To fuse over a broken bone to that extent may bring on a further injury to the surrounding flesh and set up a serious infection. So it is that the physician seeks to give you first of all what is called a good functional result. That means that he is trying to place the bones in such a position that after they are mended you will be able to use your leg or arm as before. This will not be accomplished all at once but eventually if you can recover full motion after a simple break he considers the result as excellent. Naturally he wants to place the broken bones in exact position but this is not essential to an excellent functional result.

"Fractures are painful and disabling to the patient, they frequently present most difficult problems to the physician, and so this word of caution to watch your step on the ice in the wintertime, be careful of the rug on the waxed floor, use the hall light when coming down stairs and drive carefully that you may not be the cause of such injury to others."

* * *

BIRTHMARKS

Madison, Wis., June 23.—Birthmarks on children should be treated early in life and even then there is no certainty of complete removal. Causes of birthmarks are unknown but are common, according to the Educational Committee of the State Medical Society in its weekly bulletin issued today. The bulletin declares that in some cases surgical treatment has been satisfactory but recently radium has been used with beneficial results.

"The birthmark, mother's mark, or, as it is called in scientific medicine, the angioma or nevus, represents a congenital anomaly of the blood vessels in the upper layers of the skin," declares the Medical Bulletin issued today. "Its color varies from a light red to a deep purple and while often small and almost insignificant at birth may enlarge considerably during the first few days or weeks of life. After nevi reach a certain size further growth usually subsides; in a few rare instances even spontaneous regression has been observed. However, as a rule a nevus must be treated. Besides the 'raised' or hypertrophic type of birthmark we have also a flat nevus called port wine mark or stain which may vary in size from a small spot to involvement of a whole area as, for instance, one entire side of the face. Strawberry mark is a name likewise used in some cases. In addition to those present at birth, there are some which develop later in life. It may be interesting to mention that certain nevi show growth of hair and as a rule only one birthmark is present in a child. The cause of nevi is not known.

"The treatment of birthmarks should be carried out early; there is no doubt that in young children good results are easier to accomplish than in adults. Among them any methods suggested for the removal of birthmarks only two have really stood the test of time, namely, the application of carbon dioxide snow and radium. As a matter of fact radium is gaining more and more prominence in this field. Its application is entirely painless, most convenient for the patient and the dose can be well controlled. In the hands of the experienced physician there is no danger of an untoward reaction.

"Surgical removal can, of course, be attempted; however, the cosmetic end result in cases treated properly by radium is far better. Unfortunately only the thickened type of nevus responds well to treatment; the flattened, port wine stain does not. Sometimes a fainter color can be brought about by radium application, although many radiologists do not advise radium therapy in such cases. However, we must remember that here as in all other medical problems no general pattern of treatment can be outlined. Each case has to be considered individually and treated on its own merits. The only general rule is early consultation of a competent physician in order to save loss of valuable time before beginning proper treatment."

EMBOLISM

(Continued from page 465)

COMMENT

Case I had been fibrillating at least a year and a half before her embolism, the second case permanently fibrillating only about two months. Both cases were thyrotoxic fibrillators when operated as shown by the basal metabolic rate taken when both patients were well compensated.

CONCLUSIONS

1. Embolism is a rare complication following thyroidectomy in thyrotoxic auricular fibrillation.
2. The mechanism is compared to that of embolism following quinidine therapy for auricular fibrillation.

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ELECTROTHERAPY ILLEGAL

(Continued from page 484)

The 1925 bill sponsored by the chiropractors, contained a similar definition, extended to all "articulations," but it was eliminated before passage at the instance solely of the osteopaths, who claimed that

PHYSICIANS' EXCHANGE

Advertisements for this column must be received by the 25th of the month preceding month of issue. A charge is made of $2.00 for the first appearance of copy occupying 1 inch or less of space and $1.00 for each succeeding insertion of the same copy. Kindly accompany copy with remittance to cover number of insertions desired. Advertisements from members of the State Medical Society will be accepted without charge. Such copy will be taken out after its second publication unless otherwise requested. Where numbers follow advertisements replies should be addressed care Wisconsin Medical Journal.

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the definition as so extended was a definition of osteopathy.

In May, 1928, the court decided the case of *Isaacson v. Wisconsin Casualty Ass'n*, 187 Wis. 25. While the decision dealt with the question of whether a chiropractor was a "physician" within the meaning of the workmen's compensation act, the language of the court indicates the court's view of what is meant by chiropractic. It was said that "physician" did not include "a specialist in body manipulations only such as chiropractors."

Webster defines chiropractic as "a system of healing that treats disease by manipulation of the spinal column."

Funk & Wagnalls New Standard Dictionary: "A drugless method of treating disease chiefly by manipulation of the spinal column."

New International Dictionary: "A system of manipulation which aims to cure disease by the mechanical restoration of displaced or subluxated bones, especially the vertebrae, to their normal relation.

Encyclopedia Brittanica, 14th ed., attributes the development of chiropractic to B. J. Palmer, of Davenport, and Palmer himself said, in a circular issued:

"I use only the neurocalometer, spinograph, adjusting table and my hands to get the sick well. Anything more or other than this may be something else, but it isn't chiropractic."

From this wealth of authority, it is clear that chiropractic is the adjustment of, ordinarily, the spinal column, and ordinarily only by manipulation by the hand. Also, that chiropractic does not include the use of any medicines or drugs; nor surgery; nor the use of any devices which do other than adjust, if, indeed, it permits mechanical apparatus even for adjustment.

On the definition alone, the use of electrotherapy devices is not chiropractic. The next question is, even though the use of such devices is not chiropractic, is there any law prohibiting a chiropractor from making use of them.

The definition of "treat the sick" in section 147.01 (a) is very broad. To treat the sick is "to examine into the fact, condition, or cause of human health or disease, or to treat, operate, prescribe, or advise for the same, or to undertake, advertise, announce, or hold out in any manner to do any of the said acts."

Sec. 147.02 is an absolute prohibition against treating the sick, except as authorized. If the use of electrotherapy machines is the treatment of the sick, chiropractors may not use such machines; because, as we have seen, chiropractic does not include anything other than "articular manipulations."

That such machines are used and intended for use in the treatment of the sick, as treatment of the sick is defined in sec. 147.01 (a), needs no argument. To so argue would be equivalent to arguing that clothing is to wear, food to eat, and coal to burn.

Granting, even, that chiropractors may abandon the use of the hand and adopt mechanical means of accomplishing the manipulations that are the backbone of chiropractic (i. e., an "advancement in the science,"), still chiropractors may not use electrotherapy devices, because such machines are not manipulation machines. Dr. J. C. Elsom, of the University of Wisconsin, says with reference to various of these machines:

"1. Quartz ultra violet lamp. The short rays are very bactericidal. They are sometimes used for severe reactions, notably in the removal of portwine birthmarks, and sometimes in alopecia areata, in the treatment of keloids and other scar tissue, etc. The longer wave lengths (2800 to 3100 angstrom units) are used in the air cooled lamp. The outstanding effect of these longer rays is in the prevention and cure of rickets, some forms of tuberculosis (other than pulmonary) and for their so-called 'tonic effects.' There are also certain blood changes which result from these rays, notably in the calcium and phosphorus metabolism.

"2. Infra-red lamps. These lamps give off the longer rays of the spectrum only, which consist practically entirely of heat. They are used for sprains, acute painful conditions, etc.

"3. Diathermy. This is the heating of the tissues by means of the high frequency currents, the electrical energy being changed to heat energy. It is a deeply penetrating heat and should not be used in hemorrhagic conditions or where there is pus without drainage.

"4. Sinusoidal and low voltage currents. These are forms of galvanic current. The effects are chemical or mechanical or thermal, according as applied. They are used to stimulate muscle contraction.

"5. Cautery. Electrocoagulation (from the high frequency currents) is sometimes referred to as cautery, but the effects are different. True cautery is where an intensely heated substance is applied to certain tissues. Both agencies are surgical in their application.

"6. X-ray. Most common use is for diagnostic purposes. The treatment purpose is chiefly used in cases of malignancy. A very powerful agency, and immense damage may be done and even loss of life occur from improper use.

"7. Colonic irrigators. These are of rather recent introduction. When properly applied and with correct technical knowledge, good results are being reported."

In summarizing, Dr. Elsom says that all of the agencies mentioned are specialties in medicine, because of the fact that knowledge of these methods and the technic of application comes only from much study and long experience. They should never be used except when administered by an expert.

In *Corsten v. State Industrial Commission*, 240 N. W. 834, the Wisconsin Supreme court had to deal

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with the question of whether a chiropractor was a physician within the meaning of the workmen's compensation act. In holding that a chiropractor is not a physician, the court says that under the definition of treat the sick, in ch. 147 of the Statutes, it is true that "chiropractors do treat the sick and that their treatment is 'medical treatment.' * * * But we are also of opinion that a chiropractor is not a physician as that term is used in the act *and in ch. 147.*" (Italics ours)

In that case the court discusses a bill passed by the 1931 legislature but vetoed by the governor. The bill would have expressly put chiropractors on the same footing as practitioners of Christian Science healing under the workmen's compensation act. The court points out that the bill would have made chiropractic *not medical treatment* but *in lieu* of it.

It is clear that under sec. 147.23 a chiropractor is licensed to treat the sick in no way other than by chiropractic. That chiropractors may not step outside of the field of chiropractic is obvious. See:

People v. Vogelsang, 116 N. E. 977, 221 N. Y. 290, holding that, although the medical practice act excepted Spiritualistic treatment, one who combines faith and prayer with the use of patent medicine is not immune from prosecution for violating the act.

State v. Miller, (N. D.) 229 N. W. 569, to the same effect.

People v. Krause, 291 Ill. 64, 125 N. E. 726, where a Spiritualist was held guilty of violating the medical practice act by the laying on of hands and manipulation of the shoulders of the patient.

In other words, the licensed practitioner may not step outside of the field in which he holds a license, nor can the exempted system of healing employ any means outside of such system.

There are a few cases directly in point on the subject we are dealing with:

State Board of Med. Exam. v. De Young, 143 Atl. 813, affirming 6 N. J. Misc. R. 231, 140 Atl. 676. This case held that the giving of electric treatments by any person not licensed to practice medicine and surgery is a violation of the medical practice act.

State Board of Med. Exam. v. Livesey, 143 Atl. 919, affirming 6 N. J. Misc. R. 177, 140 Atl. 444, held that a chiropractor giving electrical treatments exceeded his authority under the chiropractic license law.

State Board of Med. Exam. v. O'Neill, 6 N. J. Misc. R. 1075, 143 Atl. 814, held that a licensed osteopath had no right to use electric appliances.

State Board of Med. Exam. v. De Baun, 7 N. J. Misc. R. 1040, 147 Atl. 744, held that chiropractor giving electric treatments by placing discs on stomach and back connected with electrical machine violated the medical practice act.

Monohan v. Devinny, 225 N. Y. 601, held that a chiropractor steps outside his own field when he diagnoses and treats ailments. Note that New York has no chiropractic license law, but that its medical practice act permits license "according to the qualifications of the applicant," in other words, according to his particular system of healing. It would seem obvious that New York views chiropractic in its meaning of relieving *the cause* of disease rather than in the *treatment* of disease.

In *Larson v. State* (Texas), 285 S. W. 317, an electrical therapeutic was held a practitioner of medicine. (Texas has no chiropractic law.)

I am of the opinion that electrotherapy is not within the field of chiropractic, and that, therefore, the chiropractic license under sec. 147.23 does not authorize the use of electrotherapy.

In *Nelson v. Harrington*, 72 Wis. 591, a case of a clairvoyant, and *Kuechler v. Volgmann*, 180 Wis. 238, a case of a chiropractor, the Wisconsin court has definitely and emphatically taken the position that one who treats the sick by any method is engaged in the practice of "medicine," and subject to the medical practice act.

"What they hold themselves out to do and what they do is to treat disease." *Kuechler v. Volgmann, supra.*

I am of the opinion, therefore, that one licensed only as a chiropractor under sec. 147.23, who uses electrotherapy, violates the medical practice act and is subject to prosecution under that act.

Yours truly,

FRED M. WYLIE,
Deputy Attorney General.

FMW:L

Caption: Chiropractic under sec. 147.23, Stats., is confined to manipulations of the articulations of the human body, and one licensed only as a chiropractor under that section who uses electrotherapy violates the medical practice act and is subject to prosecution thereunder.

Court Makes Fourth Conviction for Jerry Metcher who Displays "License" from American Medical Liberty League

With a previous record of two prior convictions for practicing medicine without a license, Jerry Metcher of Appleton, formerly of Sheboygan, was found guilty for a third time of illegal practice and sentenced in May to serve a term of from one to three years at Waupun. The last two convictions were secured upon investigation by Walter Drews, investigator for the State Board of Health.

An interesting development of the latest trial was the display by Metcher of a "license" from the American Medical Lib-

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SECRETARY

erty League. This certificate is reproduced in this article. According to literature and news clippings relating to this organization, its Wisconsin chairman has been H. J. Michaels, a chiropractor, and chairman of its 1931 convention committee was D. F. Wischer, a chiropractor at 1460 Green Bay Avenue, Milwaukee.

On several occasions literature of the organization protesting against the use of iodine and toxin-antitoxin has been circulated in Wisconsin communities. At one time a letter from the league was sent to all members of the Wisconsin Legislature protesting against bills to "tighten the medical monopoly" declaring that crippled children "bled for serum like horses".

It is understood that former patients of Metcher are petitioning for his relief.

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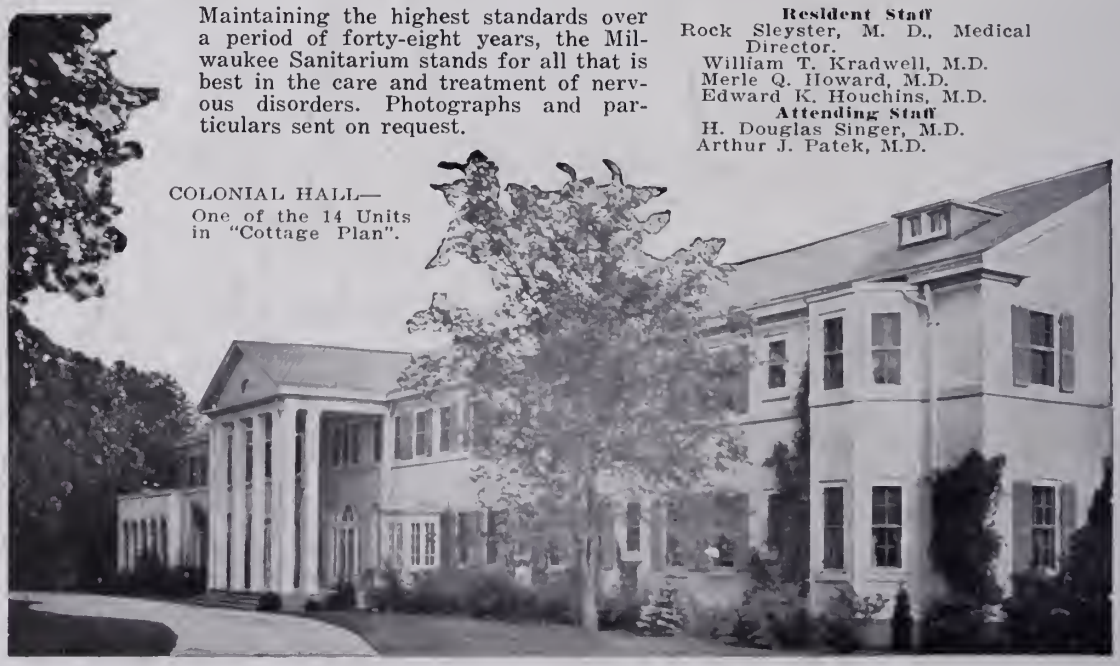

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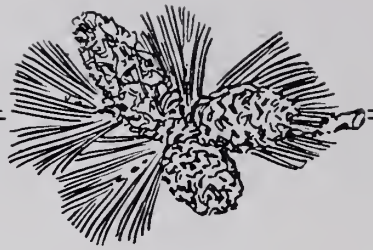

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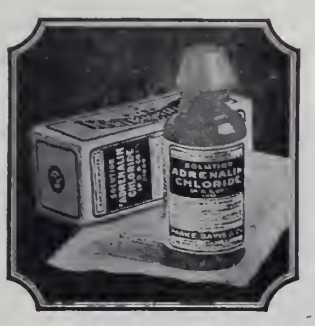

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The Wisconsin Medical Journal

Volume XXXI AUGUST, 1932 No. 8

Fractures; Skeletal Traction in the Treatment of Fractures of the Lower Extremity*

By RALPH M. CARTER, M. D.
Green Bay

In the time allotted to me, I wish to discuss the treatment of fractures of the lower extremity by means of skeletal traction, this traction being applied through the medium of the Kirschner wire. I am not trying to introduce a standard method of fracture treatment; in fact I can claim no originality for the method which I employ, as it is practically the one advocated and practiced with such marked success by Böhler of Vienna. My sole object in presenting the subject is to show the excellent results which may be obtained in the great majority of cases without open operation, with ease and comfort to both physician and patient, and to urge that those of our profession having much to do with fractures familiarize themselves with the method, and utilize it in proper cases. The results to be obtained will be a source of great gratification to all concerned.

The principle of skeletal traction in the treatment of fractures is not new, but the methods of applying it have undergone many changes. Time will not permit a review of the historical field, although this contains much of interest. Suffice it to say that skeletal traction was first put upon a practical basis when Steinmann proposed the method which is now known by his name, and which he first demonstrated in June, 1907, before the medical society of Bern. Although he was by no means the first to use the perforating nail for purposes of traction and extension, he so simplified the procedure as to render it widely applicable and generally successful when properly carried out in those cases in which it is indicated.

It is of interest to note that his method when originally proposed met with a storm of opposition and criticism, which has not entirely subsided at the present day. This opposition, then as now, arose from those unfamiliar with the method and its possibilities, and the objections were based chiefly upon the danger of infection.

ADVANTAGES

In all cases in which continued weight extension is necessary, properly applied skeletal traction offers many advantages over the methods commonly employed.

By means of it, powerful traction can be obtained immediately upon the structures which it is desired to influence. Therefore, since none of the effect is taken up and wasted upon the skin and intermediate soft parts, as is the case when adhesive plaster is employed, results may be obtained by the use of much less weight. On the other hand, if reduction proves difficult and displacement hard to overcome, as much weight as is requisite may readily be applied, with no discomfort to the patient, and with no danger of damage to the soft parts. Practically any degree of shortening may thus be combated.

To satisfactorily overcome the resistance of spasmodically contracted muscles, only a steady, correctly graduated pull is really effective. With proper attention to see that the weight hangs free, skeletal traction is regular and continuous. Once applied, it remains in place as long as needed.

Contrary to what might be expected, properly applied skeletal traction is absolutely painless. The patient is comfortable from the hour of its application. In fractures of the femur, in which treatment is necessarily of long duration, this is of inestimable value, and if the method had no other advantages over other methods to recommend it, this

* Presented before 90th Anniversary Meeting, State Medical Society of Wisconsin, Madison, Sept., 1931.

one alone would decidedly incline the scale in its favor.

In the treatment of fractures, one of the basic principles essential to success is that one fragment must be capable of being controlled. Skeletal traction assures practically complete control of the peripheral fragment, thus permitting it to be brought into correct alinement with the proximal one. Not only axial and lateral displacements, but also rotatory ones are thus easily corrected. In addition to its direct action on the peripheral fragment, because of the fact that its effect is exerted directly on the bony structures, none of it being taken up by the soft parts, skeletal traction also exerts a slight but definite influence on the proximal fragment, which is not the case with other forms of traction.

For the application of skeletal traction, only two circumscribed points are necessary, the rest of the limb being left entirely free. This constitutes one of the great advantages of the method. All the difficulties and dangers of adhesive plaster traction are thus avoided. Conspicuously absent are the usual irritation and blistering of the skin, the eczema, the disturbances of circulation, decubitus ulcers, localized gangrene, etc. It can be used in extensive wounds of the soft parts, in compound as well as in simple fractures, in conditions in which the use of adhesive plaster would be impossible.

Because of the fact that the limb is left free, care and attention may be given to the muscles and neighboring joints; stiffness is thus avoided, and after union of the fracture has taken place, the usual period of functional convalescence is much shortened.

OBJECTIONS

Since every question has two sides, objections have naturally been advanced against skeletal traction. Some of these are valid as regards some particular form of application of the traction, others rest upon an apparently sound theoretical basis which practically does not exist, and still others arise from insufficient knowledge and experience with the procedure.

The chief objection which can be urged against the employment of skeletal traction is that there exists a possible danger of infection. Certainly, with improper and careless technic, infection can occur; this is likewise true of any surgical procedure; on the other hand, with the rigidly aseptic technic which should always be employed, just as certainly infection can be avoided. This is especially true when a fine piano wire, such as that recommended by Kirschner, is used.

It has been argued that important structures such as nerves or blood vessels may be injured by the passage of a perforating pin or wire. Such a danger is non-existent if the operator makes use of the anatomical knowledge which he should possess, and selects the proper spot in which to make the insertion.

It has also been asserted that consolidation of a fracture is much slower when skeletal traction is employed. If too much weight is used, giving rise to a diastasis of the ends of the fragments, this is undoubtedly true. However, the fact simply emphasizes the necessity for frequent checking by means of the x-ray until the exact amount of weight necessary to bring the fragment ends into close apposition is found. Under these conditions, union will occur with normal rapidity.

KIRSCHNER METHOD

Theoretically and practically, substitution of the perforating nail by a fine steel wire represents a distinct advance over the older method. What has already been said in regard to the advantages and disadvantages of skeletal traction in general applies equally to traction by means of a perforating wire. But the latter method possesses additional advantages. Since the wire is itself drill pointed, it is much simpler to put through the bone than the steel pin, which must be driven in by means of a hammer or mallet. On account of the fineness of the wire, it occasions very little change in the bone structure, and on this account may be left in place for much longer periods than the pin; and finally, again on account of the small size of the wire, any possible danger of infection is reduced to a minimum.

Various ways have been suggested for putting the wire through the bone and for applying traction; the apparatus of Kirschner

is one of the simplest, and is the one which I use. In addition is needed a modification of the Braun splint, such as Böhler's, or one of several similar types which are available.

With this equipment practically any fracture, either open or closed, of the long bones of the lower extremities can be satisfactorily treated, and an excellent functional result secured without any operation more formidable than that required for the insertion of the wire. It should be clearly understood that I am excluding from this discussion fractures of the femoral neck; these constitute a separate class, and while skeletal traction may sometimes be employed with advantage in certain cases, it is by no means indicated in the great majority of such fractures; consequently they do not here enter into consideration. But to all other fractures of the shafts of the long bones which require traction, this method is applicable.

In the brief time at my disposal, a discussion of the technic of application of the traction cannot be attempted. Suffice it to say, that this technic is relatively simple, and is easily acquired. Success, however, depends upon meticulous attention to important details.

Briefly, in fractures of the femur, the wire is drilled through the bone immediately above the femoral condyles, as the site of election. If contraindications exist, such as fractures of the condyles themselves, extensive hematomata in this region, or infected open wounds, the wire is put through the tuberosity of the tibia. The traction bow is applied and the wire tightened. The patient is then put to bed, the leg is placed on the modified Braun splint, and the correct weight applied. If the wire has been put through the tibial tuberosity, at the end of three or four weeks, it will be necessary to replace the skeletal traction by some form of indirect traction, to avoid damage to the knee joint; if the wire has been passed through the femoral condyles, such a change is unnecessary. After union has occurred, the patient is fitted with a Thomas knee splint, and the treatment becomes ambulatory.

In fractures below the knee, the traction is applied through the os calcis. If the Böhler traction apparatus is available, immediate reduction is done, followed by the application of a cast, which is split longitudinally as soon as it has begun to set. The patient is then placed in bed, with the leg on the modified Braun splint, and the proper amount of traction to maintain reduction is applied. If the Böhler apparatus is not available, reduction will usually occur spontaneously if sufficient weight is applied. At the end of about three weeks, sufficient callus will have formed to hold the fragment ends in apposition; an ambulatory cast is then put on, and the patient is allowed to be up and about. In most fractures of the malleoli, traction is not necessary, and an ambulatory cast is applied immediately.

EXPERIENCE

During the past two years, my records show that I have used this method of skeletal traction in 24 cases of fractures of the femur, and in 31 cases of fracture of the tibia or of both bones of the leg below the knee. Formerly, a number of these cases, particularly the spiral fractures of the tibia, would have been operated upon, because otherwise, satisfactory reduction and retention would have been impossible. By means of wire traction, all open operations with their attendant risks of infection and prolonged healing period have been avoided. The end results, everything considered, are much better than could have been obtained by any other means. Particularly is this true of fractures of the femur. And these results have been secured with much greater comparative comfort to the patients. These statements must not be taken to mean that open operations are never necessary in fractures of the lower extremity; in certain cases they are unavoidable. What I wish to emphasize is the fact that the intelligent use of skeletal traction, applied by means of the Kirschner wire, will greatly reduce the number of cases that require operation, and that the results obtained in all cases treated conservatively will be as good as those obtained by any other procedure now commonly employed, and in most cases even better.

From my experience with this, and other methods of treatment, I am convinced that

the length of time which is required for functional restoration is definitely less when the Kirschner method is employed. To obtain evidence upon this point, a comparative statistical study was attempted, but was abandoned because of incompleteness of earlier records. This decrease in length of disability is to be attributed entirely to the excellent condition in which the neighboring joints and muscles may be maintained during the period of consolidation of the fracture, in cases of fracture of the femur by active exercise, and in cases of fracture below the knee by the use of the ambulatory cast. That a condition approximating normal is present is proved conclusively to my mind by means of the x-ray. Films show that the bone atrophy which is almost invariably present in cases which have been submitted to prolonged immobilization is conspicuous by its absence where "functional" treatment has been carried out.

As I have stated, for success with this method, close attention to essential details is important. This necessitates frequent thorough inspection, particularly in the beginning of the treatment. I am here referring especially to fractures of the femur. After a few days, with a little explanation, the average patient has grasped the underlying principles, and readily co-operates by himself seeing to it that the traction is at all times active, that the splint remains in the proper position, etc. A single daily inspection is then all that is required.

In fractures of the leg below the knee, patients with ambulatory casts are discharged from the hospital as soon as it is certain that the cast fits satisfactorily, after a few days practice with crutches or cane. Thereafter, they report to the office about twice in ten days for inspection. It is hardly necessary to state that before leaving the hospital, the evidences of trouble from cast pressure are thoroughly explained and described, and the urgent necessity for reporting immediately, should any of these evidences develop, is impressed upon them. I have seen no complications develop from this source, and I expect none; but it should be an invariable rule that every patient who is wearing a cast, and who is not under constant observation, should be instructed in this regard.

CONCLUSION

In conclusion, it must be emphasized that this is not a method to be employed by the man who treats relatively few fractures; hospital facilities and surgical experience are indispensable prerequisites. Nor is it a method which will appeal to the man who looks upon a fracture case as a rather disagreeable interruption to an otherwise well organized and fairly comfortable routine, and as such, something to be got through with with as little trouble as possible. But to those surgeons, particularly industrial surgeons, who are doing considerable fracture work, and who are conscientiously interested in improving the treatment of fractures in general and in securing better end results, I most highly recommend this method.

An Evaluation of the Modern Treatment of Ununited Fractures of the Neck of the Femur*

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During the last decade, the patient with a fractured hip has fared much better than ever before.

Through the almost universal use of the Whitman abduction method in the treatment of these fractures, the percentage of non-union has materially decreased. It still occurs in 30% of cases under the age of 60 and in 45% over the age of 60. While this improvement is laudable, there is yet too large a number of these cases terminating in the serious and painful disability of non-union.

Several surgical methods have been used in the past in the treatment for this condition:

The autogenous bone peg operation of Albee.

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The beef bone peg.
The reconstruction operations of Whitman, Albee and others.
The Brackett operation.
The Shontz osteotomy and
The Lorenz bifurcation operation.

The last two are mentioned for the sake of completeness only, as I believe they are used rarely in this country, and when used, the results are but partially satisfactory for this particular disability.

The Brackett operation is seldom used, as it is necessary to get bony union between the fractured surface of the head and the upper end of the trochanter.

The use of the beef bone peg has the same objection as that of a nail, as it adds nothing to the formation of new bone and acts only as an immobilizing agent.

The autogenous bone peg operation of Albee and the reconstruction operations more nearly fill the requirements for adequate measures in restoring function to the disabled hip.

It is obvious that, if it is possible to reestablish bony contact between the fractured head and the neck of the femur, the greatest amount of function can be restored to the injured hip. This not being feasible, the next best result can be obtained by removal of the detached head, placing the reshaped great trochanter into the acetabulum and lowering the attachment of the abductors on the shaft of the femur.

In my opinion, a more accurate application of the individual indications of these two methods will improve our results materially. Moreover, this will reduce the length of convalescence and decrease the number of cripples from this source.

AUTOGENOUS BONE PEG

The autogenous bone peg operation is not a panacea for non-union in these fractures—it is a meticulous operation, to be undertaken only under competent circumstances. But under these circumstances and in properly selected cases, a high percentage of good functional results can be accomplished. Certain requisites are essential for its success: First, the fragment of the neck should be adequate to make good contact with the proximal or head fragment, as accurate adjustment of the freshened surfaces of these fragments and secure fixation are absolutely necessary to obtain bony union; second, a patient sufficiently vigorous to survive a rather formidable operation; and third, the separated head of the femur must be viable with the articular cartilage well preserved. These indications are seldom present in those cases of non-union that have existed for one or two years. Usually the neck has disappeared through erosion and the great trochanter lays flat against the margin of the acetabulum, while the head is eburnated and pitted.

Non-union can be anticipated in 45% of sub-capitular fractures of the neck of the femur in patients of 60 years of age or over. While there a number of unfavorable factors surrounding fractures in this location, it seems to me that these statistics are inconsistent with results obtained in fractures at other sites, in patients of the same age.

Not so long ago, it was quite general practice to consider an old patient with a fractured hip unsuited for active treatment. We have outgrown this idea and it is only a step further to treat the anticipated non union before it occurs and at a time when the conditions are more nearly ideal. Some of these patients over 60 years of age are reasonably good surgical risks, especially those who have been active and vigorous up to the time of their accident.

Under proper circumstances, with our improved methods of anesthesia and in the hands of a competent operator, such cases could be given added assurance of restoration of function of the injured hip by doing an open operation, shortly after the fracture occurs. In a number of these cases an open reduction was done after the maneuvers of the Whitman Method were carried out. The injured hip was held in abduction and internal rotation on a fracture table. Upon exposing the joint, a large fold of the joint capsule was found interposed between the head and neck fragment. After removing this fold of capsule the fragments were adjusted into good position; an osteo-periosteal

graft was removed from the tibia together with some small chips of bone—small pieces of bone were chucked between the fragments of the neck and the osteo-periosteal graft wrapped around the fracture line. Actual experience shows a much shorter convalescence and obviously a more satisfactory result.

In the patients under 60, when non-union occurs, the fracture is located in close proximity to the head, where the circumference of the neck is at its smallest. These also require most exact apposition and prolonged immobilization to result in union. It is quite possible that the percentage of non-union in these cases might be lowered by an open reduction at the time of the fracture with the use of an osteo-periosteal graft or an autogenous bone peg. In many of these cases, there is an economical urge to get the greatest possible function in the shortest time. To many of these it would be little less than a tragedy to be confined for 16 to 20 weeks with its accompanying expense and loss of wage, to find at the end of that time that they have a crippled hip. An autogenous bone peg or an osteo-periosteal graft operation can be done on these patients with but little risk and bony union will usually be firm in 16 weeks.

There are also those impacted fractures which have not been recognized as fractures until four to six weeks after their injury, when the fragments have become disengaged and the fractured surfaces have healed. Large percentages of these will go on to non-union if conservative methods only are used. The fractured surfaces must be freshened and carefully coapted and a graft inserted for a reasonable expectancy of bony union.

Among the victims of the disability we are discussing, there is that unfortunate group, those with an advanced non-union. Most of these are objects of pity, many of them bedfast. Change of position is painful, is is in fact any motion. They are past the opportune time for the more conservative surgical measure. But they can be given a painless, stable hip with adequate motion. A reconstruction operation can be done even in the cases of the more delicate, without undue risk. By a comparatively simple procedure one may approach the joint through a lateral incision over the great trochanter, detach the abductor muscles together with a thin shell of bone. After turning these back, remove the head fragment. The trochanter is roughly reshaped to fit the acetabulum and levered into place. The muscles are reattached lower down on the abducted femur. The hip is immobilized for three weeks and weight bearing is permitted in 6 weeks.

This procedure is not a makeshift, but gives a very serviceable hip with a good range of motion. I believe it should be used in any case of non-union where there is much question of the success of the bone graft, or it should be especially considered in those whose health is enfeebled and in the patient who can ill afford a long convalescence.

CONCLUSIONS

Despite the improvement in the past ten years in the treatment of fractures of the neck of the femur, there are a large number of these cases resulting in non-union.

That an earlier use of the autogenous bone peg or the osteo-periosteal graft in cases where non-union may reasonably be anticipated, will prevent many of these.

That in cases where the autogenous bone peg is not indicated, a simplified reconstruction operation will give a stable, painless hip, with a serviceable range of motion.

WARNING TO MEMBERS

A lady with southern accent is approaching physicians in Wisconsin asking for appointment to have tonsils of son removed. After making appointment for operation returns later telling of husband who is ill. Uses medical terminology accurately and subsequently asks for morphine tablets for husband. Because of unsual poise and ability to discuss husband's illness, this woman is unusually skilled in her approach for morphine,—the purpose of her visits.

Observations on Duodenal Obstruction*

By R. B. JOHNSON, M. D. and
GUNNAR GUNDERSEN, M. D.
La Crosse

Every practitioner of medicine who has concerned himself about abdominal disease is undoubtedly impressed by the number of patients who present symptoms which can be ascribed to none of the so-called "common abdominal disturbances." These patients may present signs of severe intoxication with rapid death or may fall in the group of neurasthenics with chronic abdominal distress. It is our intention to present the role played by the duodenum in the production of many of these disorders since this organ has been greatly neglected in the study of abdominal disease.

The first record of duodenal obstruction is credited to Calter, who, in 1733, observed a congenital obstruction in an infant. Frederic Boerner in 1752 described the chronic form of obstruction and was followed by Yeats in 1820 who described the symptoms. In 1901, Cordes was able to gather data on fifty-seven cases of the congenital form, and Garwin in 1928 was able to collect in the literature one hundred and thirteen cases with but four records of recovery. The literature of the chronic form of stenosis has reached quite notable proportions, particularly following the work of Bloodgood in 1912 and Kellogg. The workers contributing notable articles to this subject are Duval, Beclere, Dragstedt, Wideroe, Garwin, Bachus, Higgins, Berg et al, Dixon, Bloom, Arens, Wilkie and others.

ANATOMICAL AND PHYSIOLOGICAL CONSIDERATIONS OF THE DUODENUM—HOMANS

"The duodenum, which receives the food from the stomach, differs decidedly from that organ. Whereas, the wall of the stomach is tough and muscular that of the duodenum is rather delicate and thin. The stomach delays and churns the food; the duodenum passes it along rapidly. The secretions of the stomach are acid; those of the duodenum are alkaline. Thus, the duodenum reverses the reaction of the material it receives, mixes with it bile, pancreatic and intestinal juices and initiates the intestinal phase of digestion and absorption."

"The four portions of the duodenum have each an important surgical significance. The *first portion* is directed upwards, backwards and to the right, is continuous with the pylorus, is invested, except posteriorly, by peritoneum and is suspended strongly, as a rule, by the duodenohepatic ligament, which is really the right free border of the gastrohepatic omentum. This portion is smooth internally, not covered with valvulae conniventes and to the x-ray appears as a bluntly pointed or rounded cap. This region receives the brunt of the acid gastric mixtures, is amply furnished with Brunner's glands (mucous) and with considerable lymphoid tissue. It is the usual site of duodenal ulcer. The *second portion* descends vertically and has no posterior peritoneal covering, being attached to the posterior abdominal wall close to the vertebral column. Upon the inner posterior wall of this portion, eight to ten cm. from the pylorus, the common bile duct and pancreatic duct (Wirsung) open obliquely by way of the *papilla of Vater.* About two cm above the papilla may be present the accessory pancreatic duct (Santorini), a variable structure. The *third portion* crosses the vertebral column and is altogether retroperitoneal, being covered by the mesenteric vessels of the small intestines, which are thought to compress it unduly under unusual circumstances. The *fourth portion,* short and ill-defined, rises to end in a rather acute angle—the duodenojejunal flexure—which is suspended to the left crus of the diaphragm by the ligament of Treitz. This attachment is a landmark in the performance of an anastomosis between the stomach and jejunum (gastrojejunostomy) but it is otherwise of little significance."

PATHOLOGIC ANATOMY

The duodenum, due to its embryonic development and peculiar position is particularly

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prone to pathologic deviations. The congenital occlusions may be partial or complete. The former may be a simple narrowing of the lumen or an imperforate septum. Complete occlusion occurs by an annular constriction, by a membranous diaphragm or by atresia (Garwin). No one explanation is sufficient to describe the pathology in any given case. Suton claims the malrotation takes place at the site of the "embryonal event" (liver and pancreas buds), while Tandler speaks of epithelial proliferation during the second month which later undergoes canalization. One of our cases is that of a congenital occlusion with relief following operation. Congenital occlusions except those seen in infancy are exceedingly rare as evidenced by the report of Judd and White who were able to find but two cases in the records of the Mayo Clinic.

The obstructions of the duodenum seen other than in infancy may be divided into two groups as has been suggested by Backus. The first group is an intermittent obstruction caused by arteriomesenteric pressure. There are many factors which contribute to this type of occlusion. The upright position favors pressure by the root of the mesentery since the weight of the small intestines may be carried to a large degree to the mesenteric insertion close to the duodenojejunal junction. This has been well demonstrated by cadaver experiments mentioned by Higgins who says that the duodenum may be completely occluded by pulling on the small intestine. A ptosis of the intestine, or a relaxed abdominal wall contributes greatly to produce a "drag" on the root of the mesentery. A dilated stomach, postoperative or otherwise, will sometimes produce a complete occlusion at the duodenojejunal juncture with resulting high intestinal obstruction and rapid death unless relieved by evacuation of the stomach as demonstrated by Dragstedt. Other factors that may be mentioned are a short mesentery which does not rest on the pelvis or abdominal wall, a mobile or ptosed right colon causing a pull by the median colic artery; a long transverse colon or lordosis diminishing the size of the duodenal bed and a low position of the duodenum. A neurasthenia or toxemia may have a secondary role.

The second group comprises those cases of stasis which are dependent on organic disease. According to Bloom and Arens, this group comprises all cases of duodenal stasis but we cannot from our observations agree with their conclusions. The most common concomitant lesions are adhesions from former operations or from cholecystitis. These usually involve the first and second portions of the duodenum. Other abdominal diseases which may give rise to obstruction in the duodenum are peptic ulcer which may arise as a result of the stasis, colitis, vicious circle following gastroenterostomy, duodenitis, and chronic appendicitis.

ETIOLOGY

Duodenal obstruction is much more common in women than in men. In our series, there were almost twice as many women as there were men. Stasis may be encountered at almost any age, the range in our cases being seven days and sixty-eight years. Our series of fourteen cases was gathered from a total of 15,000 registrations at the Gundersen Clinic during the last five years, that is slightly less than one per thousand cases as they came to the Clinic.

SYMPTOMATOLOGY

As has been previously mentioned, the symptoms vary from those of an acute form which result in severe toxemia and early death to those of a chronic nature with indefinite abdominal distress. In the acute form, there is severe vomiting and distention, anhydremia, and rapid loss of weight. In the congenital form, however, the symptoms of toxemia are much less severe which can be explained by the experiments of Melleney et al, as being due to the absence of the bacteria which undoubtedly have a role in the production of the toxic symptoms. In the more chronic form, there is usually abdominal pain which is often relieved by the vomiting of bile, headache, constipation, and weakness. Anemia is an occasional symptom. Besides these symptoms, arising entirely from the duodenal lesion, there may be symptoms from the concomitant pathology such as cholecystitis, colitis, appendicitis, etc.

In the more acute form, there are definite blood chemistry findings consisting of a decrease of the blood chlorides and an increase of the CO_2 combining power. There may be an increase of the blood N. P. N. and an albuminurea. The blood findings are those which have been repeatedly described as associated with an alkalosis. It is likely that the toxemia results from a combination of absorption of bacterial growth and alkalosis.

DIAGNOSIS

The diagnosis of duodenal obstruction is usually dependent on roentgenologic or operative findings; although, it may occasionally be suspected by the symptomotology. Relief of distress by the vomiting of bile is a very suggestive symptom. In the acute form the changes represented by an alkalosis speaks for a high obstruction possibly in the duodenum. Higgins has emphasized the diagnostic value of finding food rests in the duodenum while Hayes mentions the finding of tympany behind the right rectus muscle. The roentgen findings in obstruction of the terminal duodenum are dilatation and puddling of the opaque media associated with a churning movement of the duodenal content. In obstruction associated with periduodenal adhesions, there may be deformities of the cap and terminal portion of the stomach. These deformities may be differentiated from ulcer by the bizarre and inconstant shapes which the duodenal bulb assumes. Roentgenologically, there is frequently evidence of associated pathology such as gall-stones, ulcer, etc.

TREATMENT

The treatment of the acute and congenital forms of obstruction is always surgical. In the preoperative care, the value of intravenous saline solution to relieve the alkalosis and anhydremia is obvious. The operation of choice is dependent on the pathology. In cases with dense periduodenal adhesions, division of the adhesions and gastroenterostomy may be advisable. Where the obstruction is at the duodenojejunal junction, duodenojejunostomy is undoubtedly indicated.

The medical or conservative treatment consists of duodenal feedings, assuming the knee-chest position to relieve drag by the mesentery, and occasionally the use of an abdominal corset. It is usually advisable to give a high caloric diet. In cases where there is diastasis recti, abdominal wall exercise may be indicated. The necessity of treating the associated pathology is obvious.

In our series of fourteen cases (See Chart I), nine were treated by operative means while in five the treatment was of the conservative methods. The operations employed were duodenojejunostomy (1), gastroenterostomy (3), gastroenterostomy and resection (1), gastroenterostomy with division of adhesions (1) division of adhesions (1), and cholecystectomy with division of adhesions (2). In two cases, thyroidectomy was done with relief of symptoms, and in one case cholecystectomy produced no relief of distress. It is often necessary to use the medical treatment following surgical intervension. There was but one death in our series—one which occurred without operative treatment as a result of an acute occlusion.

CASE REPORT

We are reporting in detail on our one case of congenital obstruction: Baby W. T. was referred on February 5, 1930, at the age of seven days by a physician who had made a diagnosis of pyloric stenosis. The history was of vomiting since the day of birth with loss of weight and increasing icterus. Bile had been noticed in the vomitus.

Examination showed a marantic icteric infant, who showed evidence of weight loss—weight 6#. The mouth was dry and lips were crusted. The heart and lungs were normal. The abdomen was moderately distended and on inspection the outline of the stomach could be seen. Peristalic waves were observed beginning to the right of the umbilicus and radiating upward and to the left. Fluoroscopic examination showed a distended stomach and duodenum with a point of obstruction at the duodenojejunal angle. After twenty-four hours a few very small particles had passed through the obstruction but practically all the media remained as a residue in the dilated stomach and duodenum. A diagnosis of congenital stricture of the duodenojejunal junction with subtotal obstruction was made. Preoperative treatment consisted of normal salt solution by hypodermoclysis and intravenous glucose, 10%, into the longitudinal sinus. On February 7, operative treatment was done. A right rectus incision was made and an attempt to palpate the structure about the ligament of Treitz was tried. This resulted in freeing a few adhesions but failed to adequately visualize the site of obstruction. The stomach and duodenum were greatly dilated. In view of the inability to

	Age	Sex	Type of Obstruction	Associated Pathology	Duration of Illness	Treatment	Results	Diagnosis by means of
Case 1 Baby W. T.	7 da	M	Congenital subtotal obstruction at duodenojejunal junction	None	Since birth (7 days)	Operative Retrocolic gastroenterostomy	Excellent at 1½ yr.	X-ray and Operative findings
Case 2 Miss B. P.	15 yrs	F	Acute obstruction at duodenojejunal junction by root of mesentery	Chorea	2 days	Conservative	Died	Autopsy
Case 3 Mrs. P. S.	21 yrs	F	Chr. obstruction at duodenojejunal junction	Chronic Cholecystitis	5 mos.	Cholecystectomy & Appendectomy. Later posture, diet.	No relief following operation	X-ray
Case 4 Mrs. E. Z.	29 yrs	F	Chr. obstruction at duodenojejunal junction	Thyrotoxicosis; Pelvic disease	4 mos.	Conservative. Frequent feedings; alk. powders	No relief at 6 mos. Relief 1½ yrs. later	X-ray
Case 5 Mr. M. S.	26 yrs	M	Chr. duodenal obstruction due to periduodenal & perigastric adhesions	Upper abdominal adhesions	2 years	Division of adhesions. Gastric resection and gastroenterostomy	Complete relief	X-ray and Operative findings
Case 6 Miss E. N.	18 yrs	F	Chr. obstruction due to periduodenal adhesions	Upper abdominal adhesions (post operative)	3 mos.	Gastroenterostomy	Partial relief 1½ mo. Later, complete relief	X-ray and Op. findings
Case 7 Mrs. A. H.	22 yrs	F	Chr. obstruction due to periduodenal adhesions	Upper abdominal adhesions(post operative)	6 mos.	Operative—division of adhesions	Partial relief 1½ yrs. Symptoms less severe	X-ray and Op. findings
Case 8 Miss H. D.	22 yrs	F	Subacute obstruction at duodenojejunal junction	Periduodenal adhesions; Cholecystitis	4 mos.	Operative; cholecystectomy & division of adhesions. Later duodenal feedings, etc.	No relief after op.; almost complete relief after conservative	X-ray and Op. findings
Case 9 Mr. L. B.	44 yrs	M	Chr. obstruction due to periduodenal adhesions	Pericholecystic adhesions & adhesions to old operative scar	1 year	Cholecystectomy & division of adhesions about duodenum and operative scar	Relief of vomiting but pain persisted. Developed ventral hernia	Operative findings
Case 10 Mrs. R. B.	27 yrs	F	Subacute obstruction associated with periduodenal adhesions	Began as hypermnesis gravidarium. Large psychic factor. Upper abdominal adhesions	1 year	Therapeutic abortion. Gastroenterostomy. Later duodenal feedings & other supportive therapy	?	Operative findings
Case 11 Mrs. F. C.	23 yrs	F	Chronic obstruction at duodenojejunal angle	Gastroptosis	1 year	Conservative	?	X-ray
Case 12 Mrs. L. G.	47 yrs	F	Chronic obstruction associated with periduodenal adhesions	Bilateral ovarian papillary cyst; adenomata with extension and ascites	1 month	Retrocolic gastroenterostomy	Temporary relief	X-ray and Op. findings
Case 13 Mr. M. S.	31 yrs	M	Chronic obstruction at duodenojejunal junction	None	Several years	Duodenojejunostomy	Partial relief. Convalescence complicated by localized peritonitis	X-ray and Op. findings
Case 14 Mr. S. H.	68 yrs	M	Chronic obstruction at duodenojejunal junction	Toxic adenoma of thyroid	?	Thyroidectomy	Complete relief	X-ray

SUMMARY—CHART I

Age:
- Infancy—One.
- 10–20—Two.
- 30–40—Seven.
- 40–50—Two.
- Over 50—One.

Sex:
- Female—Nine.
- Male—Five.

Type of Obstruction:
- Congenital—One.
- At Duodenojejunal Junction—Seven.
- Periduodenal Adhesions—Six.

Associated Pathology:
- None—Two.
- Chorea—One.
- Cholecystitis—One; (?)—One.
- Upper Abdominal Adhesions—Six.
- Gastroptosis—One.
- Thyrotoxicosis—One.
- Ovarian Papillary Cyst Adenoma With Extension—One.

Duration of Illness:
- From seven days to several years.
- Average—One to six months.

Treatment:
- Conservative—Three.
- Operative—(a) Regional 10; (b) Remote 2.

Results:
- Died—One. Condition not recognized.
- Complete Relief—Five.
- Partial Relief—Five.
- Questionable Relief—Two.

Diagnosis:
- X-ray—Eleven.
- Postmortem—One.
- Operative Findings—Two.

force the opening at the ligament of Treitz, a retrocolic gastroenterostomy was decided upon and accomplished rather hurriedly because of the grave condition of the patient.

Post-operatively, the baby received fluids subcutaneously and per rectum as well as small quantities of breast milk at frequent intervals by mouth. Convalescence was uneventful except for a mild gastroenteritis. On March 6, 1930, the child's weight was 7℔—3 oz. X-ray showed a normal functioning gastroenterostomy. On March 4, 1931, examination showed a healthy infant of 20℔. The diet consisted of milk, strained cereals and breakfast foods. There was a small ventral hernia in the upper portion of the incision. On roentgen examination, barium was seen to pass through the pylorus into the duodenum as well as through the gastroenterostomy opening. The duodenum apparently emptied itself by reverse action into the stomach.

SUMMARY

(1) Duodenal obstruction is of fairly frequent occurrence. (2) Fourteen cases are reported—one of congenital occlusion in an infant with relief by operative treatment. In one case there was severe toxemia and death within two days. These cases have been treated for the large part by operative means with relief of symptoms in a large majority of cases.

CONCLUSIONS

When conservative means fail, operative interference offers a fair assurance of relief of symptoms in duodenal obstruction, the operation of choice being duodenojejunostomy, if relieving the obstruction by other means is impossible or impractical.

Iodized Table Salt and Goitre Surgery in Detroit*

By ROY D. McCLURE, M. D.
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Before writing this note on our experience in Detroit following the introduction of iodized salt as a prophylactic measure against goitre, I looked up my first Osler's "Practice of Medicine" published in 1905 and turned to his note on prophylaxis of goitre. It reads: "In regions in which goitre prevails the drinking water should be boiled. Change of locality is sometimes followed by cure. The medicinal treatment is very unsatisfactory. Iodine and various counter irritants externally, iodide of potash, ergot, and many other drugs are recommended by writers." Certainly no recommendations of iodine here. My old chief, Dr. William S. Halsted would with but little doubt have dismissed a house officer who might have been bold enough to prescribe iodine to a sick thyroid patient. Dr. Halsted had worked and studied with Dr. Albert Kocher in Berne, who had concluded as expressed in his published papers 1904, 1910, and 1911

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that iodine was very distinctly harmful in hyperplastic and adenomatous goitre.

Breuer in Nottinagel's Clinic in 1900 first described iodine hyperthyroidism (Jod–Basedow), also published against the use of iodine in goitre. Perhaps the idea of the harmfulness of iodine went further than Kocher had at first intended. Though used incognito in the form of sea weed and sea sponge ash by the ancient Chinese and Greeks and down through the centuries in the treatment of goitre, the result was that the use of iodine in all types of goitre was discredited, as Kocher was the leading goitre student of that day.

After the discovery of the element iodine in 1812 by Courtois of France, it was soon recommended for the treatment of goitre. Switzerland used iodized salt as a prophylactic measure against goitre as far back as 1840. In 1900 the anti-iodine group, culminating in Kocher, almost killed its use by scientific physicians both as a prophylactic measure and as a remedy for goitre—excepting in patent medicines.

This sentiment *against* iodine was taught in most of the medical schools in America in the early part of this century. As a student of the Hopkins Medical School while home on vacation in Ohio, I often made daily visits with my father, a practicing physician. I well remember reproving him for giving iodine to a goitre patient, and I now hang my head with shame, for, today, I would give that same patient iodine in even greater amount in preparation for operation.

The work of Marine and his associates, begun in the years 1907 to 1909 in the study of goitre and its relation to iodine, marks the beginning of the newer and more practical knowledge on this relationship. They again turned the spotlight of professional interest on the use of iodine as a prophylactic measure against endemic goitre. Over two thirds of the iodine in the body is found stored in the normal thyroid gland. In a normal 150 pound individual 55 mmg. of iodine is found in the thyroid gland and about 14 mmg. of iodine rather diffusely distributed elsewhere in the body.

The development of methods of reading basal metabolic rates accurately gave a new measuring stick for determining the activity of the thyroid gland. To Plummer goes the credit for turning our attention to the use of iodine in the preparation of sick goitre patients for operation. This measuring rod of the basal metabolic rate showed, however, that only temporary and partial improvement was brought about by the use of iodine.

McCollum has recently stated that thirty-five or more of the now known chemical elements are essential for a normal healthy human physiology and anatomy. Strangely enough, four or more of these elements are especially related to the perfect functioning of the glands of internal secretion. Miraculous chapters in chemistry will some day be written concerning these relationships; such as calcium and the parathyroid, or iodine and the thyroid, the relationship we are now discussing. Much has developed in the last few years in the study of calcium and the parathyroid glands.

As we absorb these necessary elements, excepting oxygen perhaps, through our alimentary canal they must be classified as foods, and not drugs. Fortunately nature is usually most prolific and wasteful, so that our bodies adjust to tremendous over indulgences as well as minimal quantities of necessary foods. If there is a swing too far either way in intake, danger signals appear and the wise heed the warning. These must be promptly and correctly interpreted by the physician who can never cease study if he is to be up to date.

Marine and especially Kimball in their studies of goitre in school children began in a systematic way to replace this deficiency of food iodine by iodine as a drug, and then again as a food in iodized salt. This juggling of iodine between the doctor, the patient, the apothecary, the dietitian, the grocer, and the average citizen in an endemic goitre area may be confusing at first. Surely the physicians have sat as judges and the decision will finally be given. So my bit of evidence as a surgical observer is presented to you as judges today.

CLINICAL CLASSIFICATION

I cannot resist at this point presenting the new goitre nomenclature recently recommended by the American Association for the Study of Goitre:

Type 1—Non-toxic Diffuse Goitre.
Type 2—Toxic Diffuse Goitre.
Type 3—Non-toxic Nodular Goitre.
Type 4—Toxic Nodular Goitre.

In spite of early training against the use of iodine in goitre, our experience in prescribing iodine tablets to dozens of young girls with adolescent goitre (non-toxic diffuse goitre) at the Henry Ford Hospital, won us over very soon as an advocate of iodine as a drug. Our experience also won us over as a supporter of Plummer in its use in exophthalmic (toxic diffuse goitre) preparatory to operation. We even have gone further and find it of benefit in toxic adenomatous (toxic nodular goitre) in preparation for operation.

MICHIGAN EXPERIENCE

Iodized salt was introduced to the population of Michigan through the fine efforts of the Advisory Committee of the Pediatric section of the Michigan State Medical Society (with Dr. D. M. Cowie as chairman of the committee), and the State Board of Health. They had the approval of the State Medical Society aided by O. P. Kimball. The work of this committee was accomplished through meetings with the salt manufacturers who cooperated splendidly in placing the product in the grocery stores throughout the State.

Iodized salt in Michigan contains .01% sodium iodide. The Committee recommended that the use of this salt should preclude the use of any other form of iodine by the population and to be effective must be used for cooking as well as table use. The salt producers estimated that each person in Michigan consumed about five or six pounds of salt per year, whereas other estimates placed it up as high as eight pounds per year. The Committee took the eight pound per year consumption as the safe average. With the above percentage of sodium iodide this would give the consumer about one milligram per day per person of sodium iodide.

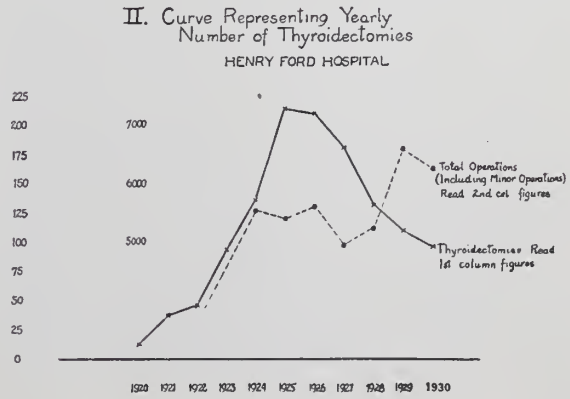
As two or three milligrams of sodium iodide per week will prevent goitre and ten milligrams has been proved to do no harm it is seen that the average per cent is well within safe limits.

However, when it was introduced to us in 1925 as a food (iodized salt) we had some misgivings as to the possible dire outcome in view of the adverse reports of such fine men as Breuer, Nottinagel, Kocher, Halsted and others of two or three decades earlier.

In a paper in 1927, I thought we might be seeing some bad results with adenomata (nodular) and that the iodized salt was bringing more adenoma cases to operation—our operation curve suggested that. The death incidence in Detroit also seemed to increase. See Chart I.

Since the introduction of iodine therapy we see fewer polar ligation operations, certainly few post operative thyroid storms occur. See Chart II.

Chart II shows the yearly number of thyroidectomies at Henry Ford Hospital. The dotted line indicates the total number of all operations performed. The drop in thy-



roidectomies is all the more striking since over the same period of time the curve of total operations has increased.

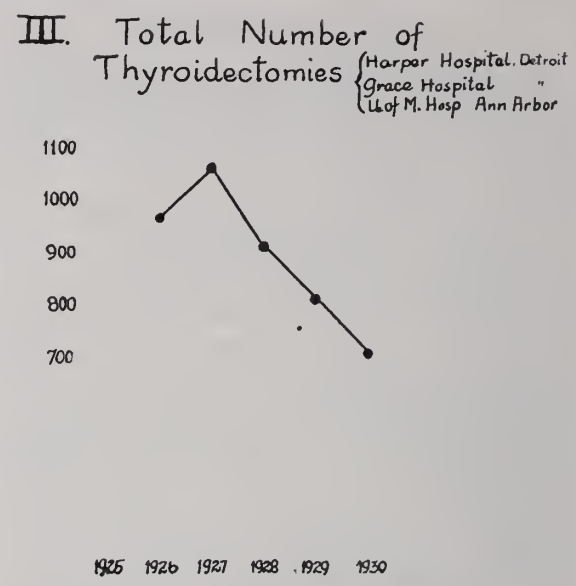
Hartsock, Plummer, Goetsch and Jackson I believe were all somewhat skeptical of the use of iodine in this way. Hartsock reported sixteen cases of iodine hyperthyroidism which Crile's Clinic felt were due to the use of iodine salt though this salt was sold in such minimal quantities there, and has not yet been approved by the profession in Ohio. A letter of August 28, 1932, from Dr. Hartsock now states, "No one at the present time sees cases which are very suspicious of this condition. The explanation I do not know, and I am very much confused in my own mind about the whole thing."

Cowie of Ann Arbor reports in a letter to me the investigation of several cases of hyperthyroidism supposed to have been induced by the use of iodine salt. "We have run down several reports of ill effects from the use of iodized salt, but in each instance we have found that the reports were fallacious."

Our old ingrained prejudice against iodine readily led us to a conclusion that any patient taking iodine and developing signs of hyperthyroidism did so because of the iodine. This may not be true. It is a fact that in the Hopkins Syphilitic Clinic in a series of 6000 patients (some taking as high as 120 grains of iodides daily for twelve months) not a single case developed hyperthyroidism. In our clinic with over 3000 luetic cases under treatment with iodides, only one or perhaps two cases have come under suspicion of developing hyperthyroidism from even larger doses of iodine than this.

We do occasionally see a non-toxic diffuse goitre in a child. Is it because they do not eat enough salt to get their quota of iodine, or is there still another factor necessary to produce goitre? Chesney and now Marine have produced goitre in animals with a diet of cabbage—but can prevent the development of the goitre on the same diet with the prophylactic use of iodine.

A letter from the largest salt distributor in Michigan of September 1, 1931, states that "in 1924 we shipped 45,079 cases of plain table salt to the State of Michigan. In 1930,

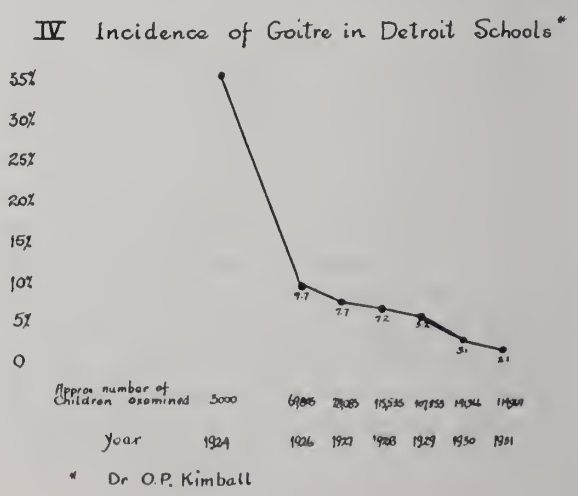


58,643 cases of iodized table salt and 7,057 cases of plain table salt." Letters from the other chief distributing salt companies correspond.

Patients report almost universally that they are using iodized salt. See Chart III.

In order to be sure that the decline in the number of thyroidectomies was not confined to our hospital, we obtained statistics from Grace Hospital and Harper Hospital, Detroit and from the University of Michigan Hospital at Ann Arbor. We combined the total yearly number reported from each hospital. This chart shows a steady decline as indicated. Unfortunately we could not obtain the figures before 1926. See Chart IV.

Is it not possible that the lessened number of thyroid operations in Michigan—an endemic goitre region, is due to the fact that



the thyroid is kept in more normal condition by the prophylactic amount of iodine in salt and thereby less susceptible to the etiological factors causing goitre. Even with the use of iodine salt in Michigan, while the total number of children with goitre is tremendously reduced, still there are a few who do have goitre. Kimball and Marine both believe that there is still an iodine deficiency due to some additional factors which cause an overtaxing of the thyroid, such as puberty, pregnancy, chronic infections, severe malnutrition, etc., to explain these cases where the thyroid enlarges.

There are still great opportunities for the investigative student first, to determine the exact function of the thyroid gland and especially its relationship to the other internal glands, such as the ovary, pituitary and adrenal; second, to determine whether there is any such clinical entity as iodine hyperthyroidism as many writers insist. Surely iodine is very limited in its benefits to the exophalmic goitre patient, except in preparation for operation. But our experience is not at all conclusive that overdosage of iodine does any harm.

The increase in the number of goitre operations and thyroid deaths for the years 1926 and 1927 following the introduction of iodine salt as in these curves shown to you, suggest some harm from its use. Subsequent years, however, show such marked diminution in incidence of goitre operations, as well as fewer deaths, that we cannot escape the conclusion that there is more than a mere coincidence in the relationship between these facts and the general use of iodine salt in Michigan.

CONCLUSIONS

1. There has been a tremendous reduction in the incidence of non-toxic diffuse goitre since the introduction of iodine salt in Michigan.

2. There has been a marked dropping off in the number of goitre operations in the Detroit and Ann Arbor areas since the introduction of this salt. The number of all operations has increased, so that relatively there is a still more marked drop.

3. We do not by any means conclude from the above facts that iodine deficiency is the only cause of goitre but we do believe that if the thyroid gland can be kept in its normal state by a sufficient intake of iodine, toxic diffuse and nodular goitres are less apt to develop.

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Carcinoma of the Esophagus*

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One of the most discouraging problems in medicine today deals with the treatment of cancer. When the esophagus is involved the outlook has so far been very nearly hopeless, but with continued study of this problem it is possible that advance can be made and a reasonably certain palliative procedure would be something in the right direction. It was not until the problems of bone sarcoma and carcinoma of the stomach and breast were thoroughly investigated that any real progress was made.

* From the Surgical Service of the University of Minnesota, Minneapolis. Presented before 90th Anniversary Meeting, State Medical Society of Wisconsin, Madison, Sept., 1931.

Carcinoma of the esophagus is not only serious because it is a malignant growth but also because this growth interferes with the ingestion of food and fluids. It is a relatively common form of cancer. Clayton found 41 cases, or 5.05 per cent, out of 812 malignancies studied at autopsy.

The cases reported in this paper were seen by the Surgical Service of the University of Minnesota in the Cancer Institute. There were 24 patients with carcinoma of the esophagus under observation and treatment from 1927 to 1930, inclusive. It is a disease of males and of late adult life, and of the 24 cases discussed in this paper 20 were in males. The average age was 61.5 years for males and 66.5 years for females. The oldest patient was 81 and the youngest 44. During this time there was also seen a case of sarcoma of the esophagus in a girl of 28 years, but this case was not included in these observations. The average duration of symptoms before the patients came to the hospital was 7.4 months. The cardinal complaint in all cases was dysphagia. Usually difficulty was first experienced with dry and coarse foods. In several cases the first food to stick was a large piece of poorly masticated or tough meat. Soon fluids only could be taken; finally, as was the case many times, nothing could be passed through into the stomach. The weight loss was striking. The greatest was 75 pounds in 15 months. The average was 39 pounds per patient. Weakness was also a prominent symptom. Regurgitation of food occurred in 6, or one-fourth, of the cases, while vomiting occurred in still another quarter. The food was usually returned about 5 or 10 minutes after eating and was undigested. Cough, epigastric and presternal pain, choking and hoarseness were symptoms which appeared in frequency as in the order named above.

Laboratory examinations were of little importance. The hemoglobin and red cell determinations were relatively high for cases of malignancy. The average for the former was 84 per cent and for the latter 4,400,000 red blood cells per cubic centimeter. The white polymorphonuclear count in those cases with perforation and lung or mediastinal infection was high. The average count, however, was only 9,700. The Wassermann examination in all of our cases was negative. When complete obstruction was present the blood urea nitrogen was found to be somewhat elevated above the normal, while the blood chlorides were often lowered.

DIAGNOSIS

The diagnosis of esophageal cancer should always be surmised whenever anyone over forty complains of difficulty in swallowing. The easiest and probably the best method of confirming or disproving this opinion is by fluoroscopic and radiographic examinations using a heavy mixture of barium to bring out the esophageal defects. Normally there are three points of constriction in the esophagus—one at the inlet, the second where the left bronchus crosses the esophagus, and the third at the entrance into the cardiac end of the stomach. These anatomical narrowings are all smooth in character in contrast with those caused by carcinoma. Above the point of tumor obstruction the dilated esophagus, as a rule, bulges quite appreciably. The differential diagnosis from an X-ray standpoint must include the following: benign cicatricial contractions due to chemical or other injury; masses in the mediastium pushing in and distorting the esophageal tube; foreign bodies lodged within the tube; large esophageal varices; and finally neurological lesions producing a prolonged spasm. Figures I, II and III illustrate several different types of lesions.

Figure IV illustrates the amount of lung involvment which follows the aspiration of food either through an esophagotracheal or esophagobronchial perforation or by overflowing into the trachea.

The most common site for this type of new growth in our series of cases was in the lower one-third of the esophagus with 9 cases situated here. There were six in the middle third and 5 in the upper third. In 4 cases the exact site was not recorded.

Esophagoscopic examination was done on one-fourth of the patients. Whenever any reasonable doubt as to the correctness of the diagnosis exists, this procedure allows the taking of a biopsy.

Fig. I.

Fig. III.

THERAPY

Therapy is unfortunately almost 100 per cent unsuccessful. If left untreated death is due to starvation unless perforation occurs with a resulting mediastinitis or lung infection. Complete excision of the lesion and a fair portion of surrounding tissue would offer us the greatest possibility of complete cure. This can be done with some hope of success in the cervical portion only. Unfortunately this is not true when the thoracic or abdominal parts are involved. It is so large an undertaking that it should only be attempted by surgeons with proper training and facilities. The results so far are anything but encouraging. Torek has one case that lived 13 years after operation and finally died of some other condition. Lilienthal had one patient survive the operation but death occurred several months later of a recurrence. Eggers had two cases survive, one of which died soon afterward of a recurrence and the other was a relatively new case when reported. If patients came to or were referred to a well trained surgeon early enough and he was familiar with the technique involved, we probably would have better results.

Formerly cancer of the esophagus was considered rather a benign type of carcinoma which did not have a tendency to metasta-

Fig. II.

Fig. IV.

size. This is not the case. Clayton in 41 autopsies found metastases in 22, or 75 per cent. In 11 of these, nodules were found in the liver. When the tissues were examined microscopically and graded as to the degree of malignancy according to Broder's classification, 9 cases were Grade IV, or the most highly malignant; 12 were in Grade III; 15 in Grade II; and only 3 in Grade I. Because of the rather cellular type of lesion frequently found one would suppose that it would respond favorably to x-ray or radium treatment. In most places x-ray treatment has been given up. Smaller doses of radium over longer periods of time seem to be somewhat more effective. Hill and Mills report fair results. Wright reports unfavorable results, while Guisez reported a few 5 year cures. Radium was used in 4 cases in our series. It was pulled into place under direct vision with the use of the fluoroscope by a string which had been previously swallowed and later hooked out of the stomach with an ordinary shoe button hook through a gastrostomy opening. The radium was allowed to remain in place as long as was necessary with very little discomfort to the patient and with no interruption in feeding. Figure V shows roentgenogram of lesion and Figure VI the radium in place.

Gastrostomy according to Abel is "little short of masterly inactivity." In picked cases it does, however, often offer great relief. The best type of gastrostomy, I believe, is the one developed at the Memorial Hospital in New York City by the late Dr. Janeway and described by Quick and Martin. They report an operative mortality of 20 per cent. In our small series of 10 cases we had three deaths, or a high mortality of 30 per cent. This was due in all probability to a poor selection of cases. It is impossible to hope to succeed in any abdominal operation when the patient is completely dehydrated and has a disturbance in his salt and nitrogen equilibrium. Preoperative medication helps a great deal but is often insufficient. In the modified Janeway gastrostomy a transverse flap is cut from the anterior stomach wall with the base at the greater curvature. A gooseneck-shaped tube containing all the walls of the stomach is made

Fig. V.

in this way and the end brought out through a stab wound in the left rectus muscle. A catheter is placed in the duodenum at the time of the operation. Its advantages are that it is permanent, it seldom leaks, feeding can be started on the day of operation, and radium can be used without a great deal of discomfort. We have had several cases where the weight gain on a high caloric diet was very gratifying. Often after the use of the gastrostomy tube the esophageal passage enlarged enough so that the patient was able to partake of food normally for several months. In other types of gastrostomy it was usually during this stage that the pa-

Fig. VI.

tient refused to keep the gastrostomy tube in place and as a result the passage closed up and he was as badly off as before the operation.

Dr. Wangensteen, Chief of the Surgical Staff, attempted one esophagectomy. The patient died several days postoperative of a bronchopneumonia. No other cases were suitable for such an attempt.

Dilation with Plummer sounds is used almost exclusively at the Mayo Clinic. Moersch and Vinson claim that it offers the most comfort with the least risk. In our hands this procedure was rather a failure.

Intubation seems to be in vogue in England more than in this country and in picked cases might offer a great deal of relief.

Diathermy through an esophagoscope has also been tried by Wright and Hadfield with fair success. Perforation or contraction may occur.

CONCLUSIONS

1. Cancer of the esophagus is found more often in men than in women and is a disease of the aged.

2. Surgery so far offers the only hope for a permanent cure, but will not be successful until surgeons acquire a better technique and operate upon more favorable cases.

3. Gastrostomy in many cases offers a great deal of relief and allows the best means of introducing the proper amounts of radium in the proper place.

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The General Practitioner's Response to the Challenge of Obstetrics*

By ARCHIE A. SKEMP, M. D.
La Crosse

For a number of years we have been told that the United States has been suffering from an epidemic of poor obstetrics, and from the standpoint of mortality and morbidity statistics our country is making the poorest record of all the civilized countries. We hear frequently that the average general practitioners are unskilled and untrained, and the Boston and Philadelphia midwives are superior to them as obstetricians. In that important convocation known as the White House conference recently held, some very interesting statistics were presented. With your permission I shall present a few of these with the feeling that they might be instructive but mainly with the hope that they might inspire us to do what we can and should to establish a satisfactory standard. And, furthermore, it will be my aim to call your attention to a few debatable features with which you may disagree, but concerning which, I have some rather inflexible feelings.

It would seem that there could be very little logic in the statements that the midwives are doing superior work, and doctors inferior work, and that this latter fact is due to lack

* Presented before 90th Anniversary Meeting, State Medical Society of Wisconsin, Madison, Sept., 1931.

of education of the physician. Logically, the inference should be that he has had too much training and I honestly believe that this is the situation. He has been shown many bits of radicalism in the technique of obstetrics and many potentially dangerous instruments and theories have been entrusted to him. Formerly the obstetrical forceps would mark the frontier of his operating efforts, but now he has forceps for every position that the child might assume in the birth canal. He has spinal and sacral anesthesias; he has tiltometers, episiotomy scissors and various types of Ceasarian sections, and he has a vast and ever increasing literature that is being constantly flaunted before him on various technical phases of obstetrics. Almost every month there is something new in the management of the occiput posterior position, and some daring step is advocated in the realm of operative obstetrics. A recent Harvard graduate told me that it seemed to him that every case they had there was a forceps delivery unless the babe was born before the doctor arrived. Students who came back from the Chicago Lying-In Hospital have no figures but many impressions, and one of the most vivid is the frequency of the use of forceps and episiotomy incisions. One of our internes, a recent graduate of Washington University, says the episiotomy incisions and forceps are routine in all deliveries of primiparae. He tells about the lecture he had on Ceasarian section, it's indications and dangers and how a plea for conservation was incorporated in the lecture. A week later the lecturer was in the act of making an incision for Caesarian section when the babe was born spontaneously. Of course you and I feel sorry for the obstetrician and an incident of this type should probably stay out of print, but it seems so dramatically emphatic that it stamps this indelible lesson where it belongs.

The majority of deaths are from infections; infection follows trauma; trauma is frequently the result of operative obstetrics, and thousands die annually from this vicious circle of activity. And how obscure are the indications! Read, if you have not already done so, A. K. Payne's article in the N. Eng. Med. Journal of Sept. 25, 1929 on the Ethics of Caesarian Section and C. Jeff. Miller's article in Surgery, Gynecology, & Obstetrics, June, 1929, and meditate on the figures that they present. At the Burnside Hospital in Toronto there was one Caersarian section for every 861 deliveries; at the Jefferson Hospital in Philadelphia one in every six was Caesarian delivery; at the Boston Lying-In, one in twelve and at the New York Lying-In, one in 585; Potter of Buffalo has one Caesarian section in every fourteen deliveries. This baffles our comprehension, especially when we contemplate the personnel of the institutions. Yes, there should be more education, but I wonder sometimes if it wouldn't be well if the tables were reversed and if the small town doctor wouldn't do well if he gave a course to the specialists and the teachers. He could tell them many things and could present many pleas. He could urge them to be less hypocritical. To teach conservatism and to practice radicalism is sacrilegious and I can conceive of nothing that has a greater tendency to mold the thoughts and actions of the youthful attendant in the dangerous field of manipulative and operative obstetrics. He would tell the teachers and writers to permit Litzenberg of the U. of Minnesota to write the chapter on occiput posterior positions, the condition which all too frequently prompts men to make some daring maneuver that they recently have read about. Let the patient have more time, even a day if she needs it and she will deliver spontaneously. What a relief compared to the present furore of Scanzoni's and modifications of Scanzoni's with innumerable manual and corrective maneuvers!

ABORTION EVIL

The general practitioner might plead with the leaders to organize in a united drive against the obortion evil. To most of us it seems absurd that it is safer to do a criminal abortion than it is to park an automobile on the wrong side of the street. Surely there is some inspiration lurking in the mind of some legislator or some university leader that if fired, could initiate the power to correct this scourge of the country—why isn't

it done? And how about this birth control propaganda! To see the shortsightedness of some of our teachers relative to this problem is indeed a sorry spectacle to most of us. On the anvil of sacrifice and hard work our ancestors pounded out the stuff that made America. They reared large families and fired them with the spirit that made our colonial and developmental history. We accept that creation and delight in the luxuries that through them we have acquired. But in the downy softness of modernism with its push button mechanisms and its birth control we are burying the heritage that our ancestors died for. Chas. Knowlton who died about the middle of the last century was one of the most forceful of the original birth control faddists. After his death and after his literature had been widely disseminated the vital statistics of England revealed such a birth decline that careful analysis showed that he was responsible for about 10,000,000 people being unborn. These represented the higher and nobler classes of Englishmen. In that number would unquestionably be some of God's finest talent and England will always suffer from the loss of so many of her geniuses. And now the voices of the Ben Lindsay's and Margaret Sanger's and Church Congresses are whispering the same heresies to the present generation, and the obstetricians and gynecologists are concurring. Let them keep it up, and the good blood of the country will be thoroughly diluted and the quality of the substance that has made America will be so devitalized that degeneration and deterioration will be inevitable. I don't presume to know as much about this subject as many of the learned clergymen who have expressed opinions—but as they have entered the realm of medicine and have become opinionated, I dare to enter the field of theology with a few thoughts at least. Birth control by contraception is a crime against biology and a sin against the law of God. It is indeed a pity that Theodore Roosevelt and his big stick could not have been at that White House conference with Howard Kelley to put to death this new devil stalking around us—a curious devil, neither real man, nor real woman, nor lowly beast—and why should obstetricians and gynecologists be associating themselves with this creature when they have so much to do in their own sphere of activity.

A CHALLENGE

Let us look at some of the figures that James McCord presented at the same meeting. In Philadelphia from 1914 to 1930 the midwives of that city attended 90,926 confinements—of this number 1,780 were delivered by physicians and in 1,281 cases physicians were called in after delivery, leaving a total of 87,865 attended solely by a midwife. Of this number there were 77 maternal deaths or a rate of 8.5 per 10,000 live births —septicaemia was the cause of death in 2 per 10,000, the average is 18 per 10,000 and even at the Lying In Hospital in Chicago the rate is about 20 maternal deaths from all causes per 10,000 births. And in this vast group of over 90,000 cases only 34 were delivered in a hospital. In Pittsburg the figures were even better though the series was much smaller. Here over a period of five years, 7,707 women were attended by midwives and only four mothers died, a mortality of five per 10,000 cases. I know of nothing in the whole realm of obstetrics so astounding as this. We frequently hear about the superiority of the Scandinavian as an obstetrician. His death scale is about 22 per 10,000 and the mortality rate in the United States is about 65 per 10,000. In 1929 our neighbor state, Minnesota, had the record in the United States with a rate of 43 per 10,000. Frankly this statistical study challenges every obstetrician and every teacher in America and this I beg to present as my answer to the challenge of obstetrics. It is up to the American professor to teach and inspire the recent graduates to be as good as midwives, after he himself has attained to such a degree of perfection by rigid conservatism.

It seems that this task should not be too overwhelming. The average senior has had an excellent laboratory and clinical background. He could be easily taught the essentials in prepartem, intrapartem and postpartem treatment. A thorough physical examination should be made preliminary to the delivery. There should be a considerate re-

moval of all foci of infection. Infected teeth, tonsils, and constipation should be attended to carefully. During delivery a trained woman should be assisting the physician to keep the patient calm until she is in the second stage. This conserves the doctor and keeps him away. I think this is of paramount importance. A nervous, restless physician administering quinine and pituitrin and making many examinations is a morbidity and mortality factor not frequently enough considered. The doctor should be kept away until he is really needed. In the home the patient should not be shaved and washed, for there is too much danger of introducing contamination into the birth canal. The dry method, that of clipping short the hair and using some efficient antiseptic such as mercurochrome and iodine, or picric acid is vastly superior. A colored antiseptic is of advantage because it outlines the surgical preparations. Then the problem is one as sacred as any surgical problem, the most rigid asepsis is practiced in everything that is done. The obstetrician should examine his conscience too and be sure that he is bringing no streptococci into this home from some case of septic sore throat, septicaemia or scarlet fever. This is another tremendous factor in the cause of sepsis. The busy practitioner making his calls amongst all types of infections should frequently meditate on this factor when he is called on confinement cases. Of course, it goes without saying that there has been a careful appraisal of the cardiovascular and urinary systems.

It has been my habit for years in a case too remote for careful supervision to instruct the mother to examine her own urine and this has been a great source of satisfaction. Assuredly, this does not cover the whole realm of obstetrics, but I am confident that in following this outline we could afford the midwives keen competition at least, and develop ultimately some real obstetricians, and in closing, may I interpret briefly the attributes of an obstetrician.

SUMMARY

A real obstetrician is one who has had a thorough training in general medicine and who is familiar with pelvic and abdominal surgery. He must have in abundance the attributes of a gentleman. He should be conservative, that is, one who knows how and when to be radical. He should see in obstetrics the most marvelous of all the dramas of life, a drama written by the Creator himself in the role of mother nature, and acted by motherhood in its most divine mood. The physician is the director and brings with him the knowledge and the wisdom and the skill that he has acquired from his preceptor, his experiences and from the expression of the ages that have gone before. He should bring safety tempered by no compromise, firmness tempered with kindliness; and a heart, a hand, and a mind coordinated with the spirit of the drama that moves on before him. And a greater calling than this has no man. Now most of what I have told you will be forgotten and so I should like to recapitulate and say that when you are asked what you heard at the convention, you can say that you heard one man make a plea for conservatism in obstetrics.

Diagnosis and Treatment of Ectopic Pregnancy*

By C. B. HATLEBERG, M. D.
Chippewa Falls

Ectopic pregnancy is difficult to recognize, and yet it supplies the operating room with more emergencies than any other lower abdominal lesion except acute appendicitis. With nothing new in mind, it is the purpose of this paper to review, for you, the diagnosis and treatment of ectopic pregnancy.

The dramatic or text book type cases are easily diagnosed, others are only found at time of operation. Some of the series of cases reported show as high as 40% error in diagnosis. Farrar states that any one who sees a large number of tubal pregnancies sees more atypical than typical cases. There will be fewer errors made in the diagnosis of ectopic pregnancy, if we will take an

* Presented before 90th Anniversary Meeting of the State Medical Society of Wisconsin, Madison, Sept., 1931.

accurate history of the present complaints and keep thinking in terms of pregnancy while taking the history. Many times patients are indefinite and state that they have had a normal menstrual period, when on detailed questioning, they admit that the last period was several days early or delayed, or that they only flowed half the usual time or flowed excessively. Many women do not keep track of their periods and are apt to give a misleading menstrual history.

DIAGNOSIS

It might be well to consider a typical case of ectopic pregnancy. The patient misses her menstrual period for a short time, and may or may not have the usual early signs of pregnancy. She then develops irregular vaginal bleeding and with the advent of tubal abortion or rupture, the patient has a sudden sharp pain in the lower abdomen from the irritation of the blood on the peritoneum. If the hemorrhage is large, she will show signs of internal hemorrhage, such as fainting, pallor, air hunger, rapid thready pulse, falling blood pressure and cold clammy extermities.

Menstrual History. Irregular vaginal bleeding is probably the commonest diagnostic symptom. One should always think of ectopic pregnancy in any woman in child bearing age, who complains of irregular bleeding or spoting. The usual history in ectopic pregnancy is amenorrhea for a few days or weeks and then irregular spotting of blood. There are only a few cases in whom one is unable to discover any menstrual irregularities. Sometimes, instead of a missed period, it is prolonged and spotting continues. About 84% of the cases of ectopic pregnancy show vaginal bleeding. A case, that gives a history of amenorrhea, if only for a few days and then has vaginal bleeding, is nearly always ectopic pregnancy.

Pain. Pain in ectopic pregnancy is the next important symptom, although it may occur more often than irregular bleeding. Farrar reports pain occurring in 96% of her series of cases. If the history is complete and reliable, some form of pain will be brought out in nearly all cases. The pain usually follows the irregular vaginal bleeding and is cramp like at first, or one severe sharp pain on the affected side in the lower abdomen. It is most often sudden in onset, sharp and intermittent in character. Some times, the cramps will seem like gas pains and be overlooked, because of previous discomfort and then again a sudden sharp pain indicates a tubal rupture with abdominal hemorrhage. Sabel states that pain is the most constant symptom, varying from moderate to severe and is usually on the affected side. The patient will have discomfort on one side due to distension of the tube from the growing ovum and then a sharp pain on rupture of the tube. In subacute cases with small hemorrhages there will be repeated attacks of pain of lesser degree. In ruptured cases, there may be pain referred to the shoulders from irritation of the diaphragm. There are a few patients who complain of pain on defecation and urination. Behney states that ⅓ of the cases have generalized abdominal pain. Sudden pain in the abdomen followed by shock, in a woman, is the usual evidence of ruptured ectopic pregnancy with internal hemorrhage. With free blood in the abdomen, many patients complain of not being able to breathe because of severe pain under the ribs. Fainting is a common symptom of ruptured ectopic pregnancy. The patient may have a complete collapse for a short time or just a feeling of faintness.

Physical Examination. The examination may reveal some of the usual signs of early uterine pregnancy. There may be abdominal rigidity and tenderness over the affected side, but these findings will not help much. A bluish discoloration of the umbilicus occur occasionally with abdominal hemorrhage and is called Cullen's Sign.

On vaginal examination one will be able to palpate a soft boggy mass on the affected side in about 85% of the cases. Before tubal abortion or rupture the mass is only slightly sensitive. The cervix will be soft, mucous membrane of bluish color and uterus slightly enlarged. After tubal abortion or rupture, movement of the cervix will cause excruciating pain on the affected side and is a most important sign if inflammatory processes have been ruled out. In patients who are easy to palpate, a corpus luteum en-

largement of the ovary may be palpated and distinguished from the mass in the tube. A tubal mass is usually more movable than an infected pelvic mass and will sometimes float anteriorly. In later cases, the mass increases in size and becomes more tender.

Laboratory. The leucocyte count will average about 14,000. Farrar has shown that there will be a rapid rise in the leucocyte count on active bleeding but drops when hemorrhage ceases. The sedimentation test is prolonged within normal ranges rather than being shortened as in acute inflammation. Unless in severe hemorrhage, the hemoglobin and red count are of no particular value. Pulse and temperature are not of much value. If the pulse is over 110, case is considered more urgent.

Colpotomy. If on an incision in the posterior vaginal fornix free blood is found in the pelvic cavity, one can nearly be sure of a case of ectopic pregnancy. An attempt should be made to remove the ectopic pregnancy through the vaginal route, if unsuccessful, then an immediate laparotomy is indicated. This is better than colpopuncture because it will demonstrate old blood or small amounts of fresh blood. Allen has removed the tubal pregnancy in 27% of his cases by colpotomy and if not successful then a laporatomy was done.

DIFFERENTIAL DIAGNOSIS

Salpingitis is the condition most difficult to differentiate from ectopic pregnancy. The pain in salpingitis is usually constant, dull, more gradual and more often to be found on both sides. The menstrual irregularities are more often menorrhagia and decreased intermenstrual periods, rather than decreased flow or missed period as in ectopic pregnancy. Frequent urination and presence of gonorrhea help to make a diagnosis of salpingitis. There will be more fluctuation of the leucocyte count and more extreme tenderness in the culdesac in ectopic pregnancy. It is very important to be able to differentiate salpingitis from ectopic pregnancy because salpingitis is treated conservatively, whereas in ectopic pregnancy immediate operation is indicated.

Appendicitis usually starts with pain in the upper abdomen which moves to the right lower quadrant. The rigidity and tenderness is more localized. The pelvic examination will reveal a negative pelvis and a tender appendix. One should always make a vaginal or rectal examination on any adult woman in whom one suspects appendicitis. A large number of ectopic pregnancy cases are operated with a diagnosis of acute appendicitis, but the mistake is not serious, because both conditions demand surgery.

Uterine abortion usually shows more profuse bleeding and more definite history of amenorrhea.

Hemorrhage from the ovaries, like rupture of either Graafian follicle or corpus luteum cysts, is usually diagnosed as ectopic pregnancy. The diagnosis of pelvic abscess is confirmed by colpotomy and if free blood is obtained, then laporatomy is performed.

TREATMENT

The treatment of ectopic pregnancy is immediate operation, removing the affected tube and controlling hemorrhage. After tubal abortion or rupture, the patient should be operated on at once. Before tubal abortion or rupture, elective operation should be method of choice. A few cases will recover spontaneously, but I believe that early operation is the more conservative treatment. An exception may be the case discovered a considerable time after tubal abortion or hemorrhage has stopped and patient is making an apparent, uneventful recovery. In cases of internal hemorrhage with shock, I believe that they should be operated at once, Douzis reports that considerable part of the first shock is due to the rupture of an abdominal viscus, rather than large loss of blood and if operated at once, there will be less loss of blood and less danger than if patient is first treated for her shock by supportive measures and then operated later. Delayed operation gives a chance for another hemorrhage which may be fatal. Large clots of blood are removed but no attempt is made to remove the free extravasted blood, which will be of considerable value to the patient. The operative cases are followed by supportive measures such as hypodermoclysis, intravenous glucose, Murphy drip, stimulants and blood transfusion, if necessary.

Ether acts as a stimulant in these cases if used for a short period and is the anesthetic of choice. The operation should be rapid. Thies recommended auto-transfusion but it is probably best to use freshly matched blood if blood transfusion is necessary. Patients usually react quickly and recovery is uneventful. The average mortality is about 4%.

CONCLUSIONS

1. Early diagnosis is imperative.
2. Accurate history is most important.
3. Ectopic pregnancy must always be ruled out in any case of a woman in childbearing age complaining of irregular menstruation and abdominal pain.
4. Colpotomy is very helpful in differential diagnosis and sometimes the ectopic pregnancy can be removed through the vaginal incision.
5. Treatment is immediate operation and removal of the affected tube and control of hemorrhage.
6. Shock is treated during or after operation by supportive means.

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THE JOURNAL CLINIC

A Note on the Acid Treatment of Hay Fever*

By HARRY BECKMAN, M. D.
Professor of Pharmacology, Marquette University
Milwaukee

For several years I[1] have been advocating the use of the following formula in the treatment of hay fever:

℞

Nitrohydrochloric acid (N. F.)	ʒ iv ss	18.0
Water	to make ℥ iv	120.0

Label: One teaspoonful in ⅔ glass of water, followed by another glass of water, after meals and again on retiring as near mid-night as possible.

In the present report I wish to bring the results of this treatment statistically to date. Table I is a reprint of the last statistical study, published in 1930, when the total number of cases had reached 237.

Table 2 comprises a similar arrangement of the 281 cases which have accumulated since that time. In Table 3 there is reprinted a statistical study of the results obtained in the desensitization treatment of the malady. Table 4 offers a comparison of the results obtained in the 518 acid-treated cases with that in the 2,185 desensitization-treated cases.

Of these acid-treated cases, only 24 have been seen by me personally; 142 were reported to me in answer to a questionnaire sent out in 1928. The remaining 352 cases have been reported to me without solicitation by physicians residing in all parts of the country. I am showing here in the tables the report of each individual physician because the disparity in classifying between "complete" and "marked" relief is thus brought out, and it is also shown that percentage estimates based upon small numbers are worthless. The final percentages are of course computed only from the total figures.

In their recent exhaustive treatise on the allergic diseases, Coca, Walzer and Thommen[2] state their belief that this acid therapy is the most promising of the new departures in the treatment of hay fever, and

* Presented before Milwaukee Academy of Medicine, 1932.

TABLE 1.

Relief Obtained by Acid Therapy in Two Hundred and Thirty-Seven Cases of Hay-Fever

Number of Cases	Relief		Per Cent of Success	Number of Cases	Relief		Per Cent of Success
	Complete	Marked			Complete	Marked	
21	18	2	85	4	1	2	75
10	7	1	80	1	--	1	100
13	5	7	92	1	1	--	100
22	--	--	0	33	--	6	18
2	1	1	100	3	--	3	100
8	1	2	38	6	4	2	100
11	6	2	73	1	--	1	100
6	4	2	100	6	6	--	100
6	3	2	83	10	4	5	90
5	1	2	60	2	1	--	50
2	2	--	100	12	4	5	75
6	4	2	100	5	2	3	100
4	--	2	50	14	3	9	85
10	--	--	0	3	1	1	66
14	8	4	86	6	1	3	66
2	--	--	0	4	--	1	25
2	--	--	0	2	--	1	50

Total number of cases ---------- 237
Number of cases obtaining complete or marked relief ---------- 160
Percentage obtaining complete or marked relief ---------- 67

TABLE 2.

Relief Obtained by Acid Therapy in 281 Cases of Hay-Fever

No. Cases	Relief		Percent Success	No. Cases	Relief		Percent Success
	Complete	Marked			Complete	Marked	
23	9	10	81	8	--	--	0
21	7	5	57	8	--	6	75
18	7	4	61	8	2	5	87
18	16	--	89	8	3	4	87
18	--	12	66	8	3	3	75
17	--	4	23	7	1	6	100
14	9	3	85	7	3	3	85
12	2	6	66	4	4	--	100
10	10	--	100	4	4	--	100
10	5	5	100	4	--	4	100
10	3	5	80	4	2	2	50
10	3	6	90	4	--	--	0
8	4	--	50	4	--	3	70
8	3	5	100	3	--	--	0
				3	--	2	66

Total number of cases ---------- 281
Number of cases obtaining marked or complete relief ---------- 203
Percentage obtaining marked or complete relief ---------- 72

TABLE 3.

Relief Obtained by Desensitization in 2,185 Cases of Hay-Fever

Authority	Number of Cases	Relief (in Per Cent)			
		Complete	Marked	Slight	None
Rackemann: New England M. J. 84 : 585, 1925	91	9.0	62.0	----	28.0
Vander Veer: Am. J. M. Sc. 164 : 97 (July) 1922	1,744	23.0	49.0	18.0	10.0
Bernton: J. A. M. A. 80 : 1301 (May 5) 1923	56	25.0	40.0	24.0	10.0
Piness: J. A. M. A. 84 : 584 (Feb. 21) 1925	202	29.6	40.0	21.4	9.1
Smith: Mil. Surgeon 61 : 560 (Nov.) 1927	92	10.0	65.0	19.0	6.0
Averages (per cent)		19.3	51.2	20.6	12.6

Average success (per cent) ---------- 70.5
Average failure (per cent) ---------- 33.2

TABLE 4.

Comparison of Results in Acid and Desensitization Treatment of Hay-Fever

	No. Cases	Complete Relief	Marked Relief	Successfully treated (Marked plus Complete)	No Relief
Acid treatment	518	36%	33%	69%	31%
Desensitization	2,185	19%	51%	70%	30%

I truly believe that this is so. Even granting the force of the many objections to a too literal interpretation of statistics obtained as mine have been, it must be apparent that a considerable proportion of hay fever patients who are being treated with the acid are obtaining relief. In attempting to evaluate my figures, the three following considerations must also be borne in mind:

(1) The statistical results of desensitization are reported by expert allergists; I think it not untrue to say that the average practitioner obtains only 40 to 50 percent of good results with this method of treatment, rather than the 70 percent shown in the present table.

(2) The acid-treated cases are principally reported by general practitioners, who do not of course have comparable control over their cases. In fact, a number of physicians have written that they were reporting certain of their cases as failures only because they did not again hear from them after prescribing for the first time. Did the patients toss away the bottle in disgust after one taste of the acid, or did they continue to have the prescription re-filled without returning to cheer the doctor by a favorable report? One physician talked the matter over with his druggist at the end of the season and then wrote me that two of his "lost" patients had tried to interest the druggist to join them in "patenting" the prescription after their first bottle!

(3) Undoubtedly many cases reported as failures might have obtained some relief had the dose been increased or the time interval between doses decreased. Last year in my own person I was obliged to take a full dose every two hours in order to obtain the accustomed relief. With this large dosage of course some diuresis is induced, but I do not think that any other deleterious effects need be feared. It is also likely that the adjustment of the diet toward the acid side by the elimination of green vegetables and fruits, and the liberal taking of meats, fats and cereals, would be helpful.

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EDITORIALS

THE NEUROGENIC ORIGIN OF PEPTIC ULCER

IN A recent article Cushing* has reviewed several experiences which seem to associate the eitology of peptic ulcer with neurogenic disturbances. His interest in this problem was aroused by eleven cases of gastric hemorrhage, some associated with perforation and peritonitis, following operations involving the interbrain. This led to an extensive survey of the literature and revealed the fact that similar findings have been described by previous observers. Rokitansky in 1841 described cases with acute perforating ulcers and hemorrhagic erosions of the stomach, which he considered as related in some way to reflex action of the oesophageal and gastric branches of the vagus. Similar erosive changes in the stomach have been observed in the new-born suffering from intracranial trauma.

In 1845 Schiff observed that an experimental lesion of the interbrain would often lead to softening of the stomach and sometimes to actual perforation. He attributed these changes to neuroparalytic hyperaemia of the mucosa as the result of injury to the central pathway for vasomotor nerves of the stomach. He also observed that direct stimulation of several portions of the basal nuclei and pons caused gastric movements similar to those produced by stimulation of the vagus. Furthermore, these movements were prevented by section of the vagi.

Differences of opinion regarding the etiology of peptic ulcer are largely based on the original conflict of ideas expressed in the views of Rokitansky and Virchow. Virchow was responsible for the conception that peptic ulcer is primarily due to local causes and as Cushing states, "Out of this has come the highly unprofitable search for its primary cause in the walls of the stomach itself, whether they be vascular, traumatic, bacterial, chemical or secretory in origin." Under the influence of Virchow's theory a vast amount of research has been carried out trying to produce peptic ulcer by local changes in the stomach. In contrast, as Cushing states, "The discredited view of Rokitansky that the disorder has a neurogenic origin has slowly but surely gained ground as our knowledge of the vegetative nervous system has increased."

Cushing visualizes the presence in the midbrain of a parasympathetic center intimately connected with the various nuclei in the midbrain and especially with the vagal nuclei in the medulla. Functional as well as organic disturbances in this center may lead to unusual vagal activity, which in some cases may cause serious gastric disturbances. It is probable also that this parasympathetic center is strongly influenced by cerebral or emotional influences. This may be of importance in nervous individuals under emo-

* Surgery, Gynecology & Obstetrics, Vol. 55, July, 1932.

tional stress, continued worry or heavy responsibility, particularly if these emotional factors are combined with hygienic errors and the excessive use of tobacco. Such an association may lead to chronic indigestion with increased muscular activity, possibly in some cases accompanied by areas of terminal vascular spasm, which may cause small areas of ischemic infarction, thus leaving the overlying mucous membrane subject to the digestive action of its own hyperacid secretions.

This theory has a great many plausible points for it is undoubtedly true that ulceration of the stomach and duodenum has markedly increased under modern conditions. Cushing quotes his colleague Christian in the observation "That the incidence of many maladies commonly seen in his wards during the past fifteen years has remained stationary or fallen off, whereas gastric and duodenal ulcer has increased fourfold and this can scarcely be attributed wholly to improved methods of diagnosis." Furthermore, peptic ulcers occur spontaneously only in man and the increased prevalence of duodenal ulcers would seem in some way associated with the stress and strain of present living habits.

The plausibility of this hypothesis is enhanced by a careful perusal of the complete article. However, attempts to attribute organic changes, such as peptic ulcer, to neurogenic disturbances in individuals with an apparently normal nervous system, have always encountered considerable resistance. In the cases presented by Cushing definite neurological damage existed. The possibility of peptic ulcer arising on the basis described above must be admitted. However, if the neurogenic basis for peptic ulcer is accepted, the question arises in many cases: Is the neurogenic error primary or itself the result of some underlying perversion of metabolism or focal infection? J.H.

BASIC SCIENCE LAW PRAISED

RECOGNITION that in the Basic Science law, pioneered by Wisconsin, lies the only protection to the public from the uneducated practitioner who would prey upon the sick through fraud and deceit was contained in the report of Louis S. Reed, Ph.D., issued under the auspices of the Committee on the Costs of Medical Care. The following extract from the report will be of interest to every Wisconsin physician whose State Society succeeded in passing the first law of this type in the United States:

"There are two ways of dealing with the problem constituted by the existence of unqualified medical sectarians. One is the non-legal, and involves striking at the cultists by removing the causes which lead people to go to them. The second involves the legal suppression of the sectarians. The first approach, being the more fundamental, is in the long run the simpler and more effective. The major factors responsible for the growth of cults are credulity, ignorance, and superstition on the part of the public. It is obvious that if the cults are to be eradicated, these failings must be remedied and people must learn more about the make-up and functioning of the human body. Furthermore, it is only as people gain an intelligent understanding of the human body that they can be led to understand the necessity for legal suppression of unqualified healing practitioners. To the extent that certain deficiencies in medical practice have contributed to the rise of present-day sects, the removal of those deficiencies will aid in the eradication of the sects.

"The second way of eliminating unqualified sectarians is through laws regulating the healing art. At the present time in the United States the legislative regulation of the healing art—regulation designed to protect the public from unqualified practitioners—is not accomplishing its acknowledged purpose. All it does is to maintain high standards for one group of practitioners. Quite illogically, it also sanctions the existence, on a lower plane of qualifications, of many thousands of poorly trained practitioners. Manifestly, if the public is to be adequately protected, there must be a single minimum standard of qualifications for all healing practitioners.

"Insofar as medical sectarianism can be controlled by legislation, that end can probably be best achieved through the medium of basic science laws."

THE PRESIDENT'S PAGE

TO THE HOUSE OF DELEGATES

THE 1932 session of the House of Delegates promises to be one of the most important in its history. Matters of great significance alike to the profession and the public are to come before this body for action, and to act intelligently will require that each member shall contribute of his time and thought not only during, but before coming to the meeting.

Among the subjects on the agendum is the question of interrelation of the public, the profession, and the Wisconsin General Hospital. The report of a special committee investigating this matter will be in your hands in time to give opportunity for careful consideration of the facts and the data collected.

Again at this time the care of the indigent, and the professional and social responsibility for such care, must have careful attention if we are to give proper instructions to the legislative committee for the introduction of legislation looking toward amelioration of the inadequacies and evils of the present system. The Committee on the Distribution of Medical Services in Wisconsin has a rather detailed, comprehensive and excellent report on the distribution and cost of medical care in this state, which, together with reports of special committees, will give us a very comprehensive view of the economic condition of the public at large, of the profession in particular, of the hospital, of contract practice, and of a number of other related subjects. This Committee report in conclusion submits a number of recommendations which it will be your duty and responsibility to approve or reject. Further, you must determine whether the work which this committee has been pursuing is of sufficient consequence, sufficient importance, to be continued, or whether you shall be satisfied with what has been accomplished.

Again, you must determine what appropriation shall be made for the conduct or the affairs of the Society for the coming year, and by what means these expenditures should be met. You must decide if it is possible to lower the dues and still carry on the many very important projects and the professional program of the Society. Since the 1933 meeting of the American Medical Association is to be held in Milwaukee, we will undoubtedly be called upon to take some action in this matter.

The legislative program for the coming year is a very comprehensive one and will engage your attention, your time, your action, not only at the time of the meeting, but quite as much during the next session of the legislature.

Each delegate must feel the responsibility which as representative of the constituent Societies he owes to such bodies, to the profession and to the public. To have accepted office presumes the recognition of responsibility to perform duties of such office to the best of one's ability. It is to be hoped, therefore, that every delegate, every alternate, every member of the House will study conscientiously and carefully each of the reports that come to him and think deeply and constructively on each of them so that he may be prepared to give of his best to the end of a successful solution to these problems.

Let us make the 1932 session of the House of Delegates memorable not only because of full and punctual attendance, not only because of the variety and importance of the subject matter on the agendum, but because by intelligent and careful preparation and study we shall be enabled to make wise decisions and take helpful action in the interest of the public and to the benefit of the profession of Wisconsin.

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LIST OF EXECUTIVE OFFICERS OF COUNTY MEDICAL SOCIETIES

County	President	Secretary
Ashland-Bayfield-Iron	John M. Dodd, Jr., Ashland	J. W. Prentice, Ashland.
Barron-Washburn-Sawyer-Burnett	C. F. Cronk, Cameron	A. D. Galloway, Barron.
Brown-Kewaunee	E. S. Knox, Green Bay	W. E. Mueller, Green Bay.
Calumet	A. C. Engel, New Holstein	J. W. Goggins, Chilton.
Chippewa	F. T. McHugh, Chippewa Falls	J. A. Kelly, Chippewa Falls.
Clark	R. R. Rath, Granton	A. L. Schemmer, Colby.
Columbia	K. A. Snyder, Portage	H. Y. Fredrick, Westfield.
Crawford	A. E. Dillman, Steuben	C. A. Armstrong, Prairie du Chien.
Dane	F. F. Bowman, Madison	F. L. Weston, Madison.
Dodge	E. P. Webb, Beaver Dam	A. W. Hammond, Beaver Dam.
Door	John Hirschboeck, Forestville	
Douglas	H. A. Sincock, Superior	C. H. Christiansen, Superior.
Eau Claire and Associated Counties	E. E. Tupper, Eau Claire	P. G. Spelbring, Eau Claire.
Fond du Lac	J. C. Yockey, Fond du Lac	H. R. Sharpe, Fond du Lac.
Grant	C. M. Schuldt, Platteville	M. B. Glasier, Bloomington.
Green	W. B. Gnagi, Sr., Monroe	J. F. Mauermann, Monroe.
Green Lake-Waushara-Adams	G. E. Baldwin, Green Lake	A. J. Wiesender, Berlin.
Iowa	S. R. Ridley, Mineral Point	H. M. Walker, Dodgeville.
Jefferson	A. C. Nickels, Watertown	A. A. Busse, Jefferson.
Juneau	C. A. Vogel, Elroy	A. T. Gregory, Mauston.
Kenosha	A. Schlapik, Kenosha	W. H. Lipman, Kenosha.
La Crosse	R. L. Eagan, La Crosse	G. D. Reay, La Crosse.
Lafayette	R. B. Quinn, Darlington	W. B. Williams, Argyle.
Langlade	C. E. Zellmer, Antigo	J. C. Wright, Antigo.
Lincoln	F. L. Kelley, Merrill	W. H. Bayer, Merrill.
Manitowoc	C. H. Barnstein, Newton	E. C. Cary, Reedsville.
Marathon	Joseph F. Smith, Wausau	Verne E. Eastman, Wausau.
Marinette-Florence	T. J. Redelings, Marinette	C. H. Boren, Marinette.
Milwaukee	P. M. Currer, Milwaukee	Theo. Wiprud, Ex. Sec'y, Milw.
Monroe	A. E. Winter, Tomah	H. H. Williams, Sparta.
Oconto	R. J. Goggins, Oconto Falls	G. W. Krahn, Oconto Falls.
Oneida-Forest-Vilas	C. D. Packard, Rhinelander	I. E. Schick, Rhinelander.
Outagamie	E. F. Mielke, Appleton	R. V. Landis, Appleton.
Pierce-St. Croix	H. P. Conway, Spring Valley	A. E. McMahon, Glenwood City.
Polk	L. O. Simenstad, Osceola	Geo. B. Larson, Frederic.
Portage	F. A. Marrs, Stevens Point	H. P. Benn, Stevens Point.
Price-Taylor	F. W. Mitchell, Medford	G. L. Baker, Westby.
Racine	C. O. Schaefer, Racine	Susan Jones, Racine.
Richland	W. C. Edwards, Richland Center	G. Benson, Richland Center.
Rock	G. S. Metcalf, Janesville	E. C. Hartman, Janesville.
Sauk	Roger Cahoon, Baraboo	A. C. Edwards, Baraboo.
Shawano	C. E. Stubenvoll, Shawano	L. W. Peterson, Shawano.
Sheboygan	H. F. Deicher, Plymouth	A. C. Radloff, Plymouth.
Trempealeau-Jackson-Buffalo	R. L. Alvarez, Galesville	R. L. MacCornack, Whitehall.
Vernon	W. M. Trowbridge, Viroqua	Wm. H. Remer, Chaseburg.
Walworth	S. G. Meany, East Troy	V. S. Downs, Lake Geneva.
Washington-Ozaukee	O. J. Hurth, Cedarburg	P. M. Kauth, West Bend.
Waukesha	J. C. Hassall, Oconomowoc	J. F. Wilkinson, Oconomowoc.
Waupaca	R. K. Irvine, Manawa	F. J. Pfeifer, New London.
Winnebago	G. E. Forkin, Menasha	M. C. Haines, Oshkosh.
Wood	F. X. Pomainville, Wisconsin Rapids	W. G. Sexton, Marshfield.

SOCIETY PROCEEDINGS

MANITOWOC

A meeting of the Manitowoc County Medical Society was held July 12th at the Hotel Manitowoc.

Dr. A. H. Heidner of West Bend, councilor of the fifth district, was the principal speaker at this meeting.

ROCK

The last meeting for the summer season of the Rock County Medical Society and the Woman's Auxiliary was held in Beloit on June 21st. Dinner was served at six-thirty o'clock for the physicians.

Following the dinner, Dr. J. J. Moore of Chicago discussed the subject of cancer and presented a motion picture. Dr. Paul G. Dick, roentgenologist of Chicago, also read a paper on this subject.

A six-thirty o'clock dinner was served at the Green Gables for the members of the Woman's Auxiliary.

RACINE

The regular June meeting of the Racine County Medical Society was held on the 16th in the afternoon and evening. The meeting was devoted to the surgical treatment of tuberculosis, and the program was presented by men of national prominence in this field.

Dr. W. H. Waterson of Hines Memorial Hospital, Chicago, discussed artificial pneumothorax at length; i. e., the artificial collapse of the lung by means of gas injections into the chest cavity, a process of proven merit in enhancing the healing in tuberculosis.

Dr. Carl A. Hedblom, professor of surgery at the University of Illinois, was to have been present to give a lecture on thoracoplasty, a massive surgical collapse of the lung, also of paramount importance in the treatment of tuberculosis. Due to the inability of Dr. Hedblom to be present in person, his first assistaint, Dr. Van Hazel, very ably presented this part of the program.

Movie films were used to bring out the technique and procedure in this work.

Also on the program was a most interesting new development in the treatment of osteomyelitis, tuberculous and pyogenic, by the use of living maggots. This was presented by Dr. S. H. Livingston of the orthopedic division of Hines Memorial Hospital of Chicago, Illinois. He also used lantern slides and movies to bring out the details of his subject.

The meeting began at five-thirty p. m. with a dinner at the Sanatorium. Among the speakers were Dr. Hoyt Dearholt, executive secretary of the Wisconsin Anti-Tuberculosis Association, Dr. Chas. Stoddard, President of the Wisconsin Anti-Tuberculosis Association, Mr. L. E. Coughlin, chairman of the County Board of Supervisors, and Mr. Henry Wiegand, a member of the board of trustees of Sunny Rest Sanatorium.

Among those attending the meeting were a number of physicians from Kenosha, Milwaukee, Janesville, South Milwaukee, and Cudahy.

On Thursday the physicians and their families held their annual picnic, at which time a baseball game between the north and south side was staged, and many other "stunts" were provided. S. J.

WINNEBAGO

The June meeting of the Winnebago County Medical Society was held at Theda Clark Hospital at Neenah on the 24th.

Dr. R. B. Rogers of Neenah read a paper on "Whither Are We Drifting." Discussion was led by Dr. F. Gregory Connell of Oshkosh.

NINTH COUNCILOR DISTRICT

The summer meeting of the Ninth Councilor District Medical Society was held at Marshfield on the afternoon and evening of July 14th. The afternoon meeting was held at St. Joseph's hospital at three o'clock with the following program:

"Cirrhosis of the Liver" by Dr. Paul F. Doege, Marshfield.

Medical clinic by Dr. Francis D. Murphy, professor of medicine, Marquette University School of Medicine.

"Morbidity and Mortality Factors in Hyperthyroidism" by Dr. W. A. O'Brien, associate professor of pathology, University of Minnesota. After a six-thirty o'clock dinner at the Hotel Charles, the following talks were given:

"The treatment of Cardiac Failure" by Dr. Francis D. Murphy.

"The Cults" by Dr. Wm. A. O'Brien.

FOREST COUNTY ASSOCIATION

The Forest County Association of Physicians has been organized during the early summer. The purpose of the Association is to afford a forum for the discussion of socio-economic problems common to physicians practicing in Forest County and to afford further opportunity for scientific study.

Officers of the Association are Drs. C. O. Decker, Crandon, President; J. F. W. Clark, Laona, Treasurer; E. G. Ovitz, Laona, Vice President and R. G. Noer, Wabeno, Secretary. Other members include Drs. E. W. Huth, Crandon; G. W. Ison, Crandon and O. S. Tenley of Wabeno. Recent meetings of the Association have been given over to the discussion of medical relief for the indigent in the county.

The Association will hold meetings twice a month during the summer and monthly meetings will be held during the winter.

THE WOMAN'S AUXILIARY

Mrs. Orvil O'Neal, Ripon, Editor

Mrs. Rock Sleyster of Wauwatosa has been appointed General Chairman of the Convention Committee for the 1933 national meeting of the Woman's Auxiliary to be held in Milwaukee during the National Convention of the American Medical Association.

There were 918 women registering at our New Orleans May meeting, and it is said to have been a most impressive convention. The department of Press and Publicity was well represented in the exhibits. The Regional Scrap books were of interest, and showed thoughtful care in their preparation, and received much deserved attention. The State Scrap Books of Minnesota, Wisconsin and Oregon were also exhibited.

* * *

The induction into the office of president of Mrs. Walter Jackson Freeman brought to the Convention her inaugural address. "In taking over the direction of this great organization," Mrs. Freeman said, in part, "I find myself confronted by an almost overwhelming responsibility. In addition to the daily office routine, in itself no mean task, there is an endless succession of important decisions to be made, policies to be formulated, precedents to be established, addresses to be prepared, Auxiliaries to be visited. The duties of the position demand a really superhuman combination of wisdom, tact, discrimination, forbearance, and above all imagination, housed in a brain and body as strong as granite, as elastic as a spring, and as efficient as a robot. I have the greater handicap of following a woman of superior ability, one whose administration has been marked by magnificent constructive work, reaching out to the smallest, most remote county group, directing their undertakings, providing the needed educational material, and when time, distance and physical strength permitted, inspiring by her presence. Mrs. McGlothlan has given you a great administration and has set an impossible standard.

"My first encouragement comes from the excellence of the officers elected and from the action of the Board in confirming the appointments of chairmen of standing committees.

"In starting the work of the year there are four points to which I wish particularly to direct your attention:

1. Business methods.

"The first is your business administration, above all that bugbear of the uninitiated, that life saver of secretaries and treasurers, the fiscal year. No organization of any kind, in which the payment of dues is an obligation, can function properly without a fixed calendar date on which the treasurer's books are closed for the year, a sort of Greenwich meridan from which to reckon membership longitude.

"To facilitate the work of keeping proper membership records the use of the treasurers' receipt books has been made mandatory, and is now practically universal. To supplement these the national Auxiliary is now inaugurating a uniform membership card filing system, also mandatory.

2. Archives.

"The second point which I wish to stress is archives. Archives are the meat and drink of the historian, and the Auxiliary is, I firmly believe, destined to occupy so important a place in organized medicine that all details of its founding and development are of real value. . . . Now, however, as the vision of the future unrolls before our eyes, and while the founders are still with us to establish the facts, let us all hasten to write them down before they are lost forever.

3. Public Relations.

"How often, I wonder, are organization chairmen met with the objection that a community is "over-organized" and that there is nothing for the Auxiliary to do? The "over-organized" community is exactly the one in which the Auxiliary is most needed and finds its greatest opportunity.

'How far that little candle throws his beams!
So shines a good deed in a naughty world!

"These words apply perfectly to many Auxiliary activities, and yet the most important work is often done *through other organizations*, the Auxiliary members suggesting and guiding the work along lines approved byt he Medical Society and the health officials.

. . . Obviously, the more organizations, the wider the field for Auxiliary influence, the greater the opportunity to contribute our mite not only to community health but to the understanding by the public of the work and the ideals of the medical profession.

4. Happiness.

"We hear much of the inevitable sacrifices of the doctor's wife, only too well known to us all, but what of her rewards? Here again the Auxiliary has the answer. Not only does it offer her unrivalled opportunities for the service of humanity, but by that very service a new bond of sympathy and understanding is created between the doctor and his wife. Again and again do I find mention in the Medical Journals from all parts of the country of the new interest in their husband's work taken by Auxiliary members, of their better understanding of the imperative demands made on a physician.

"And, so, as the fourth and chiefest of the thoughts I want you to bear in mind throughout the year, I offer you the great prize of happiness, the knowledge that work in the Auxiliary . . . draws you and your husband ever closer together."

NEWS ITEMS AND PERSONALS

Dr. A. J. McCarey of Green Bay has received from the War Department the Medal of The Purple Heart, for exceptionally meritorious and conspicuous services during the Argonne action.

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Walter J. Ward, son of Dr. and Mrs. M. W. Ward of Bangor died in St. Mary's Hospital in Sparta on June 28th following an automobile accident on highway 16 outside of Sparta on June 23rd.

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Dr. H. O. Delaney of Beloit was appointed city health officer on a part time basis at a recent meeting of the city council.

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Dr. W. J. Meek, professor of physiology, University of Wisconsin Medical School, was appointed a member of the National Research Council for the division of medical science. The appointment was made upon recommendation of the American Physiological Society of which Dr. Meek has been president for the past three years.

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Dr. F. M. Mulvaney of Marion moved his offices from the First National Bank building to his residence.

—△—

Drs. J. J. McCarthy and L. W. Peterson, Sun Prairie, who have been associates in practice for the past four years, dissolved partnership on July first. Dr. McCarthy has not as yet announced his plans for the future but Dr. Peterson will remain in the same offices and will be assisted by Dr. M. E. Wyant, who has been resident physician at St. Mary's Hospital for the past two years.

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Dr. G. S. Metcalf, Janesville, was elected president of the Janesville Board of Education.

—△—

Dr. John Tasche, Sr., of Sheboygan left on July 7th for Europe where he plans to spend about two months visiting clinics. On his return, he will be accompanied by his son, Dr. John Tasche, Jr., who has been studying at the University of Breslau, Prussia.

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At a meeting of the Richland Hospital Board in July, the members voted to reduce the price of rooms in amounts varying from twenty-five cents to one dollar a day.

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Dr. Rudolf J. Noer of Wabeno has accepted an appointment on the faculty of the University of Wisconsin Medical School and will begin his new duties in September. Dr. O. S. Tenley, also of Wabeno, will take over Dr. Noer's practice on September first.

Dr. David T. Jones of Wausau is recovering from severe injuries received when the car he was driving was hit broadside by another car. Dr. Jones sustained two fractured ribs and many bruises.

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Dr. W. M. Wochos of Kewaunee was named director of the Union Free High School of Kewaunee.

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At a joint meeting of the Optimist, Kiwanis and Rotary Clubs of Sheboygan, Dr. Arthur J. Cramp, director of the bureau of investigation of the American Medical Association, was the principal speaker. His subject was "Patent Medicines and the Public."

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Dr. Karl W. Smith and family of Madison left on July 14th for an outing and fishing trip of ten days at Lake Papoose near Winchester.

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Leland and Harold Pomainville, twin sons of Dr. and Mrs. George Pomainville of Nekoosa, have received their degrees as doctors of medicine. They attended school together at the University of Wisconsin from which place they received their degrees of Bachelors of Science. Leland received his Doctor of Medicine degree at the University of Wisconsin Medical School and Harold at Temple University in Philadelphia. Leland completed his intern work in the Milwaukee County Hospital and has been appointed resident physician for the coming year while Harold will enter the same hospital on July first to begin intern work.

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Dr. Joseph C. Dean, son of Dr. Joseph Dean of Madison has finished interneship at the Philadelphia General Hospital and will study the next three months at Rochester. Returning to Madison, he will become associated with the Dean Clinic, Madison.

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Construction of a two-story municipal hospital at Reedsburg was started the first week in July, to be ready for occupancy by December first. The hospital is to have thirty beds and complete surgical equipment. Individuals and organizations have contributed towards furnishing thirteen rooms. The site and $1,000 were also donated.

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Dr. A. C. Hammett, for many years a practicing physician in Chicago has moved to Crivitz, Wisconsin, to establish his practice.

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Dr. C. N. Sonnenburg of Sheboygan has announced his candidacy for the office of coroner of Sheboygan County at the fall election on the Republican ticket.

Dr. Arthur J. Knauf of Sheboygan has also announced his candidacy for this office on the Democratic ticket.

Dr. and Mrs. Robert M. Wheeler of Madison spent a week's vacation at Star Lake near Manitowish.

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A bequest of $75,000 was willed to the Sheboygan Hospital Association to be used in the Sheboygan Memorial hospital which is nearing completion, by Robert Jaeger, retired town of Sheboygan farmer.

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Dr. Robert Benson, son of Dr. Gideon Benson of Richland Center, left the early part of July for Santa Barbara, California to begin interne work at the Cottage Hospital there.

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Dr. H. P. Greeley and family, Madison, left for the east the end of June where Dr. Greeley resumed his teaching at the Harvard summer school.

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Ann MacGregor, seven, only daughter of Dr. and Mrs. J. W. MacGregor of Portage, died on June 20th at a Madison hospital, following an illness which began last December.

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Dr. J. B. Oliver of Ripon left for Chicago on July first where he will take a three year course in surgery at Passavant hospital, Northwestern University Medical School. Dr. David F. Cole, Sparta, will take over the practice of Dr. Oliver.

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St. Mary's Hospital in Green Bay was made the beneficiary in the sum of approximately $15,000 in the will of Mrs. Margaret A. Diamond, who died June 10th.

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Dr. E. B. Pfefferkorn of Oshkosh, medical director of Sunnyview Sanatorium, attended the National Tuberculosis Association meeting at Colorado Springs in June.

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Dr. J. C. Wright of Antigo attended the 50th anniversary reunion of the class of 1882 of Rush Medical College held on June 13th at the Congress Hotel, Chicago. Nine members of this class were able to attend. At the invitation of the class of 1912, they joined them at a smoker at which Dr. Morris Fishbein presided as toastmaster. Talks were given by all present.

On his return home, Dr. Wright was accompanied to Antigo by Dr. H. M. Lynch of West Bend, who spent a few days fishing there.

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Dr. Benjamin I. Brindley announces the opening of an office for the treatment of Eye, Ear, Nose and Throat at 905 University Avenue, Suite 416, University Avenue National Bank Building, Madison, Wisconsin.

—△—

Manning a row boat with a friend, Dr. F. W. Hammond, Manitowoc, was instrumental in rescuing a man and two women from an over-turned sailboat at Twin Lakes, Conover, in July. Dr. Hammond and his companion had to row a mile and a half in order to reach the capsized boat to which the three were clinging.

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Dr. C. C. Davin, assistant city health officer at Kenosha will return to private practice specializing in eye, ear, nose and throat.

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Dr. and Mrs. William S. Middleton of the University of Wisconsin returned in July from a month's vacation in the east.

—△—

Dr. William D. Harvie, Fond du Lac, long associated with Dr. A. J. Pullen, has opened an office in the Koepnick building.

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Dr. F. B. Welch, city health officer of Janesville, enjoyed a two weeks' trip on the Great Lakes the latter part of July.

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The Biennial Conference of Social Work will hold its meeting on September 24th, 25th and 26th, according to Mr. Aubrey Williams, Secretary.

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Dr. H. H. Milbee, Marshfield, has been elected president of the Marshfield Clinic succeeding Dr. K. W. Doege, deceased.

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MILWAUKEE

A new free clinic for children and a Woman's Auxiliary to St. Joseph's Hospital have been organized with Mrs. Frank E. Darling, Jr., as President; Mrs. John W. Powers, Vice-president; Mrs. William Jermain, Secretary, and Mrs. William F. Grotjan, Treasurer.

The Auxiliary will promote the social and financial interests of the Hospital and will give special attention to the clinic to which charitable organizations may take indigent children for medical care.

The Board of Directors of the Auxiliary is made up of the following members: Mrs. Fred Stratton, Mrs. Louis Jermain, Mrs. James C. Sargent, Mrs. John Scollard, and Mrs. Harry Heeb. Mrs. Francis D. Murphy is Chairman of the Constitutional Committee.

The following physicians will act as an advisory board to the Auxiliary: Drs. Felix Schmidt, Louis Jermain, and Frank E. Darling, Sr.

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Mr. Theodore Wiprud, executive secretary of The Medical Society of Milwaukee County, addressed the Washington–Ozaukee County Medical Society at Cedarburg on June the 30th. His subject was "The Doctor Becomes Business-Minded."

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Dr. and Mrs. Wilbur LeCron and daughter, Miss Peggy LeCron, left on June 26th for a few weeks' motor trip through Canada.

Dr. Charles S. Stern was appointed health commissioner of West Allis on June 21st. He succeeds Dr. S. McCorkle who has held the office for the past ten years.

Dr. Stern has been on the staff of the Milwaukee Children's Hospital for three years and with the County Hospital for two years.

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Dr. and Mrs. Edward Quick and daughter, Miss Louise Quick, left on June 24th to spend a few days at Green Lake.

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Dr. and Mrs. A. H. Cohn and family are spending the summer months at their country home, Villa Cohnhein, at Conover, Wisconsin.

—△—

Dr. and Mrs. A. W. Gray left early in July to spend several weeks at Trout Lake.

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Dr. and Mrs. Roland Cron left on July 1st for Fish Creek, Wisconsin, where they expect to spend several weeks.

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Peter Hood, four-year old son of Dr. and Mrs. A. J. Hood, was drowned on June 28th. Besides his parents Peter is survived by two brothers, Frank and John, and one sister, Jane.

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Dr. and Mrs. E. J. Kettlehut left the city on July the second on a motor trip to Denver, Colorado. They expect to return the early part of August.

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Dr. Paul Brehm who has practiced medicine in Milwaukee for the past several years gave up his practice the latter part of June and left on July the second for South America where he expects to remain for one or two years. Dr. Brehm's practice has been taken over by Dr. Roy W. Benton, formerly associated with the A. O. Smith medical department.

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Dr. and Mrs. Harry J. Heeb are spending the month of July in northern Wisconsin.

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Dr. and Mrs. H. G. Martin motored to Three Lakes, Wisconsin, on July 1st, where they expect to remain until about the middle of August.

—△—

Committees of representatives of the insurance companies and The Medical Society of Milwaukee County have been appointed for the purpose of considering problems that arise between insurance companies and the medical profession. At the last meeting of the Board of Directors of the Society Drs. T. S. O'Malley, R. E. Fitzgerald, and Ralph P. Sproule were appointed to represent the Society, and Dr. Paul M. Currer, President of the Society, has been informed that Mr. H. G. Barelman, of the Employers Mutual Liability Insurance Company, Mr. E. E. Langworthy, of the Travelers Insurance Company, and Mr. George Goetz, of the United States Fidelity and Guaranty Company, will represent the insurance companies.

The third annual picnic of The Medical Society of Milwaukee County was held at the Usinger Estate in Fox Point on June the 25th. Not as large a crowd as was expected was on hand, due to the threatening weather, but what was lacking in numbers was made up for in enthusiasm and all who attended entered readily into the many games and sports planned by the Social Committee, of which Dr. Harry O. Zurheide is Chairman, and Drs. R. H. Frederick, C. W. Long, W. W. Hume, and A. H. Lahmann, are members. Prizes were awarded for all contests which were planned for both the children and the grown-ups.

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Dr. Arthur Walter Hankwitz, son of Dr. and Mrs. P. G. Hankwitz, left Milwaukee July 15th for a year's study in Vienna, Austria. Dr. Hankwitz, a graduate of Washington University, recently made a Diplomate of the National Board, completed his hospital service at the St. Louis City Hospital.

BIRTHS

A daughter to Dr. and Mrs. D. V. Elconin, Milwaukee, on June 24th.

A son to Dr. and Mrs. M. E. Gabor, Milwaukee, on June 29th.

MARRIAGES

Dr. Henry Rettig, Milwaukee, to Miss Margaret Stepka, Milwaukee, on July 2nd.

Dr. M. A. Flatley, Antigo, to Miss Honora M. Flawley, Eau Claire, on July 13th at New York City.

DEATHS

Dr. Benjamin Franklin Armbruster, Milwaukee, died suddenly on July 4th at Milwaukee Hospital.

Dr. Armbruster was born in Greenville, Indiana, in 1873. His medical training was acquired at the Hospital College of Medicine, Louisville, Kentucky, from which he was graduated in the year 1902. For many years he was a member of the staff of St. Luke's Hospital and had practiced medicine in Milwaukee for the past twenty-five years.

He was a member of the Medical Society of Milwaukee County, the State Medical Society, and was a fellow of the American Medical Association.

He is survived by his widow, two sons, Dr. John L., and Benjamin F. Jr., and a daughter, Miss Sally L.

Dr. Philip Fox, Madison, died on June 24th at his home where he had been confined with an illness for the past year.

Dr. Fox was born March 27, 1840, at Lexington, Indiana. He was educated at Sinsinawa Mound, Iowa, and received his medical degree from Bellevue Hospital Medical College, New York City, in 1863. Immediately after graduation, he entered the Union

army as assistant surgeon to the Second Wisconsin Volunteers. He was a member of the Iron Brigade and served through the battles of Wilderness, Spottsylvania, Cold Harbor, and North Anna. At the close of the war, he came to Madison and from 1866 to 1872 he practiced medicine with his uncle, Dr. William H. Fox, Oregon. He then moved to Janesville and practiced there until 1877. On Jan. 1, 1877 he returned to Madison and continued his practice until 1917 when he retired. Dr. Fox was the godfather of Governor Philip F. La Follette, for whom the Governor was named.

Dr. Fox was a member of Dane County Medical Society, the State Medical Society, and the American Medical Association.

He is survived by one son, Dr. Philip R., Madison, and a daughter, Mrs. Carl E. Hilbert, Madison.

Dr. J. B. Goddard, Eau Claire, died on June 25th at Freeport, Ill. Dr. Goddard was born in Lena, Stephenson County, Illinois, Oct. 25, 1856. He was a graduate of Knox College, Galesburg, and of Rush Medical College in 1888. He began practice at Winslow, Ill., remaining there until 1891 when he went to Europe and spent a year and a half at Berlin and Vienna, taking postgraduate work. On his return to the United States he located at Austin, Ill., remaining there until coming to Eau Claire in 1900.

He was a member of Eau Claire and Associated Counties Medical Society, the State Medical Society, and the American Medical Association.

He is survived by three sisters, all living in Freeport.

Dr. F. W. Mitchell, Medford, died on July first of a heart attack. Dr. Mitchell was born in Freeport, Ill., in 1864. He was a graduate of the Chicago College of Medicine and Surgery in 1887. He practiced in Ogema for twenty years before coming to Medford.

He was a member of Price–Taylor County Medical Society, the State Medical Society, and the American Medical Association.

He is survived by his widow, one son and two daughters.

Dr. Karl W. Doege, Marshfield, President of the State Medical Society in 1929, died at his home on June 28th of coronary thrombosis. He had been ill since June 10th, a few weeks following his return from Europe.

Dr. Doege was born in Stettin, Germany, April 22, 1867. When fourteen years of age, his parents immigrated to the United States. A few months after arrival in this country he entered Engelmann's School of Milwaukee and the following year entered the German–American Seminary of Milwaukee to become a teacher. Here he graduated in 1885, and when eighteen years of age occupied the position of special teacher of German language at St. Paul, Minnesota. The following year he occupied a similar position in Cleveland, Ohio. After teaching one year at Cleveland, he entered Western Reserve Medical School, where he obtained his degree of Doctor of Medicine in 1890. A month later he opened an office in Marshfield, Wisconsin, where he remained in active practice up to the time of his death.

In 1889 he was married to Frieda Walz of Cleveland. Their two sons, Karl and Paul, followed in the footsteps of their father, became graduates in medicine and are now members of the Marshfield Clinic. Mrs. Doege died July 19, 1927.

Dr. Doege did post-graduate work one year in Germany in 1896–1897; three months at Johns Hopkins in 1902, and again abroad in Vienna and Berlin in 1921, returning there at intervals. His last trip was made on March 17th of this year.

In 1917 Dr. Doege, with six other physicians, organized the Marshfield Clinic, an organization of which he had always been president. At the time of his death, he was chief-of-staff of St. Joseph's Hospital, and was a preceptor of the University of Wisconsin Medical School.

Dr. Doege was a member of Wood County Medical Society, the State Medical Society, and a fellow of the American Medical Association. He was also a member of the American College of Surgeons, and as a member of Deutsche Chirurgische Gesellschaft of Berlin, Germany, he made many trips to Berlin to attend and lecture at meetings of that society.

In November, 1930, Dr. Doege was married to Elizabeth Myerof at Hildesheim, Germany.

He is survived by his widow and two sons, Drs. Karl H., and Paul F. of Marshfield.

Dr. George Christiansen, formerly of Galesville, died on July 13th at Winona, Minnesota.

Dr. Christiansen was born in the year 1886 and was a graduate of Northwestern University College of Medicine in 1911. He served internship at Lutheran hospital in La Crosse and then opened practice in Galesville in 1917. He was one of the founders of the Galesville Clinic and was a member of the staff of St. Francis Hospital in La Crosse. Ill health forced him to retire from practice two years ago and leave Wisconsin for a warmer climate. He remained in Glendale, Arizona, until about a month ago when he returned to Galesville.

He was a former member of the Trempealeau–Jackson–Buffalo County Medical Society, the State Medical Society, and the American Medical Association.

He is survived by his widow, one son and one daughter.

Dr. George W. Pattee, 93, Janesville, died at the home of his daughter on July 14th. Dr. Pattee was born in Highgate, Vermont, Oct. 18, 1839, and for the last eighty years of his life had been a resident of Jefferson County, Wisconsin.

Graduating from Northwestern University in 1870 he practiced at Concord, Sullivan and Whitewater. He is survived by a daughter and two grandsons.

SOCIETY RECORDS

New Members

E. B. Williams, Oshkosh.
J. P. Canavan, Neenah.
S. C. Fain, The Waukesha Spa, Inc., Waukesha.
Edward J. O'Neill, 2906 W. Forest Home Ave., Milwaukee.

Changes in Address

J. E. Donnell, Des Plaines, Ill., to Cuba City, Wis.
F. J. Diamond, Loyal to Stevens Point.

» » » CORRESPONDENCE « « «

FROM INDIANA

Indiana State Medical Association

June 23, 1932.

Mr. George Crownhart, Secretary,
State Medical Society of Wisconsin,
Madison, Wisconsin.

Dear Mr. Crownhart:

Will you please send us a copy of the summary you prepared on state laws relating to the medical relief of the indigent?

Thanking you in advance, I am

Yours sincerely,
Thomas A. Hendricks,
Executive Secretary.

"CONCISE AND CLEAR"

County Court for Rock County
Probate Court

Janesville, Wis., June 23, 1932.

State Medical Society of Wisconsin,
Washington Building,
Madison, Wisconsin.

Gentlemen:

Judge Earle has a copy of your "Summary of Wisconsin Poor Relief Laws Affecting Care of Indigent Sick," and at his request I am writing for two more copies of this pamphlet.

It is so concise and clear that I would like a copy for my own use, and the Superintendent of our Rock County Poor Relief office is desirous of having a copy for his use.

Thank you. I enclose stamped envelope.

Sincerely,
Gertrude B. McCue,
Register in Probate.

WARNING TO NURSES IN INDUSTRY

State Board of Health
Capitol Building

Madison, Wisconsin, June 27, 1932.

To the Industrial Nurses Employed in Wisconsin:

Through the courtesy of the Secretary of the State Board of Health and the Secretary of the State Medical Society, I was permitted to read several letters which were written in behalf of an employee of an industrial plant who had sought and secured first aid from the nurse employed there.

The man sought relief from a condition which did not appear to be serious when he first presented himself for aid. The nurse administered a second treatment late in the afternoon of that same day and gave directions for home treatment. A third visit to the nurse, which took place the next day, showed a very much inflamed condition of the part affected. The nurse administered another treatment and suggested that he see his own physician.

The next day the patient was unable to work because of his condition. In the afternoon he again reported to the nurse and admitted that he had not seen the physician but had applied his own treatments. He promised at that time that he would see his physician. The following day he again reported to the nurse for treatment and because his condition became very much worse, the nurse became alarmed, questioned the man closely, and found that he had not seen the physician though he lead the nurse to believe that he had made contact with him. The nurse phoned the doctor's office in order to check the man's statement and found that he had not been there. The nurse then refused to treat him further and the patient finally secured medical attention.

This man now has a permanent disability, according to the doctor who is familiar with this case and who reported the case to the County Medical Society, and he states that his permanent disability may have been caused or greatly aggravated because the nurse did not insist upon immediate medical attention.

The Wisconsin State Medical Society recently prepared a pamphlet, "Standing Orders for Registered Nurses Employed in Industrial Plants", a copy of which has been sent to you. This very clearly outlines that the nurse shall administer first aid and first aid only, and no subsequent treatments should be given unless the nurse has written or standing orders from the physician employed by the plant, or the physician treating the case, so that there may

BASIC SCIENCE EXAMINATION

The next examination by the Wisconsin State Board of Examiners in the Basic Sciences will be held on September 17, 1932, 8 until 5, at the Loraine Hotel, Madison, Wis.

Application to be made to Robert N. Bauer, secretary, 3414 W. Wisconsin Ave., Milwaukee, Wis.

be no misunderstanding about the nurse's responsibility.

Though we do not often contact the industrial nurses, it seems proper at this time to sound a word of warning. Wherever the plant employs a physician, he will give you, upon request, written orders so that you may know what to do. If there is no physician employed, administer first aid and send the patient to his family physician at once for further treatment. Under no circumstances continue treatment without medical direction. It is well that you should have an understanding with the officials of the plant so that experiences, like the one enumerated herein, shall not occur in the plant where you are employed.

Trusting that you will accept this letter in the spirit in which it is written; namely, to point out the danger of serving beyond our capacity, I am

Sincerely yours,

Cornelia van Kooy, R. N.,
Director, Bureau of Public Health Nursing.

Preliminary Program by Days Announced for Annual Meeting in Milwaukee, September 14th, 15th and 16th

Drs. Geo. W. Crile, Cleveland, and David Barr, St. Louis, will present the orations in surgery and medicine at the 91st anniversary meeting to be held in the Schroeder Hotel, Milwaukee, on September 14 to 16.

Dr. Geo. W. Crile is the founder of the Cleveland Clinic and Professor Emeritus of Surgery at Western Reserve University School of Medicine. He is a speaker of international reputation and needs no introduction to a Wisconsin audience.

Dr. Crile will speak on "Denervation of the Adrenal Glands".

Dr. David Barr, Busch Professor of Medicine at Washington University School of Medicine, St. Louis, will present the oration in medicine and has chosen as his subject "The Parathyroid Glands and their Relation to Calcium Metabolism."

Other guest speakers for the session include Max Cutler, Director of the Tumor Clinic, Michael Reese Hospital, who will speak on the Clinical and Pathological Aspects of the Cancer Problem; Udo Wile, Professor of Dermatology and Syphilology at the University of Michigan, who will speak on Occult Syphilis—A Neglected Factor in Diagnosis and Treatment; W. W. Duke of Kansas City, recognized as an outstanding authority, who will discuss allergy; Samuel Amberg, Associate Professor of Pediatrics at the University of Minnesota Graduate School of Medicine, who will discuss Abdominal Conditions in Childhood; Chas. H. Watkins of Rochester, Minnesota, who will speak on Leukopenia and Acute Leukemia; Ellsworth S. Smith, Professor Emeritus of Clinical Medicine at Washington University School of Medicine, who will speak on The Treatment of Heart Disease; E. T. Bell, Professor of Pathology at the University of Minnesota, who will speak on the Etiology and Pathology of Nephritis; and Professor Julius Bauer of Vienna, Austria, who will discuss Constitution in Relation to Disease. Dr. Bauer is a very clear speaker with excellent command of English, so that there need be no fear of difficulty in understanding him. He has an international reputation as an investigator and author, especially in the field of endocrinology and the influence of constitutional traits on disease.

The annual dinner will be held on Thursday, September 15. Dr. Richard E. Scammon, who will be the speaker of the evening, is Dean of Medical Sciences at the University of Minnesota. Dr. Scammon has chosen as his subject The Foundation and Early History of St. Bartholomew's—The First Hospital in London.

On Wednesday morning, September 14, between the hours of 8 and 10, hospital clinics and demonstrations will be held at ten of the Milwaukee hospitals. These clinics will consist of case presentations, ward visits, demonstrations, and in some instances of operative clinics. In many of the hospitals the attendance necessarily must be limited to a small group and consequently admission to all hospital clinics will be by ticket only. To avoid disappointment, registration should be made in advance of the meeting through the Secretary's office.

As in previous years during part of the meeting, divided sessions will be held. On Wednesday morning these meetings will start promptly at 10:20. An attempt has been made to bring together in the same

session subjects of allied interest. The schedule is so arranged, however, that the papers will start at the same time in different session rooms, thus making possible a selection of papers according to individual interest. The papers of these sessions will be followed by general discussion.

The success of the round table meetings in the past has been such that provision this year is made for 12 luncheon meetings. Those provide in a very desirable way for informal discussion of various problems in medicine, surgery, and the specialties.

WEDNESDAY, SEPTEMBER 14

8:00–10:00. Hospital clinics and demonstrations. (Admission by ticket only.)

Children's Hospital. (Limited to 50.)
Wisconsin Avenue at 17th Street.
Case presentations, ward visits, and demonstrations of apparatus and technique.

Columbia Hospital. (Limited to 75.)
3321 N. Maryland Avenue.
Presentation of cases. Clinical and pathological demonstrations.

Milwaukee Hospital. (Limited to 25.)
2200 W. Kilbourn Avenue.
Bronchoscopic clinic.
Dr. John S. Gordon.
Demonstration of urological cases.
Drs. Fletcher and Bourne.
Ward demonstrations.
Dr. O. R. Lillie.
Carcinoma of the rectum, with report of cases.
Dr. C. A. Evans.

Milwaukee Maternity and General Hospital. (Limited to 50.)
1845 N. 4th Street.
Obstetrical clinic.
Gastro-enterological clinic.

Misericordia Hospital. (Limited to 20.)
2224 W. Juneau Avenue.
Obstetrical clinic—Caesarean section.
Presentation of Cases.
Drs. L. J. Foley, E. Gramling, Wm. A. Ryan, and V. Taugher.

Mount Sinai Hospital. (Limited to 150.)
908 N. 12th Street.
Clinical-pathological conference. Presentation of case histories, clinical data, and pathological findings.

Milwaukee County Hospital. (Limited to 150.)
Wauwatosa.
Clinical—pathological conference.
Dr. Francis D. Murphy and Dr. John Grill.
Orthopedic clinic.
Dr. Herman Schumm.
The Treatment of Acute Empyema.
Dr. Joseph M. King.

St. Mary's Hospital. (Limited to 75.)
2320 N. Lake Drive.
Orthopedic clinic.
Dr. Frederick M. Miller.
Surgical clinics—operations.
Dr. Dexter H. Witte.
Dr. Ernest W. Miller.
Presentation of pathological material.
Dr. Edward L. Miloslavich.
Medical clinic.
Dr. Arthur F. Rheineck.

St. Joseph's Hospital. (Limited to 50.)
5000 W. Chambers Street.
Clinics and demonstrations in general surgery, urology, and orthopedic surgery.
Drs. C. Echols, F. A. Stratton, Jas. Sargent, and J. W. Powers.

St. Luke's Hospital (Limited to 40.)
230 W. Madison Street (between 2nd and 3rd streets).
Acute appendicitis.
Dr. Henry J. Gramling.
Treatment of intestinal obstruction.
Dr. E. H. Mensing.
Hematuria.
Dr. W. J. Carson.
Oblique fracture of the femur.
Dr. J. V. Zivnuska.
Treatment of cardiac emergency.
Drs. John Huston and E. L. Tharinger.
Perforation of ventral hernia during pregnancy.
Dr. Stanley L. Krzysko.
Mediastinal tumor.
Dr. Joseph Gramling.
Coronary artery diseases.
Dr. W. V. Nelson.

WEDNESDAY, SEPT. 14—10:20–12:00

ROOM A

10:20. Treatment of Osteomyelitis. Lantern slides.
Dr. Walter J. Jones, Fond du Lac.

10:45. Intussuception.
Dr. L. W. Peterson, Shawano.

11:10. Anal Fissures.
Dr. A. C. Gorder, Milwaukee.

11:35. The Ambulatory Treatment of Hemorrhoids: Analysis of over twelve hundred cases.
Dr. J. M. Scantleton, Sparta.

ROOM B

10:20. Keeping the Worker Well and Keeping the Practice of Medicine in the Hands of the Medical Profession.
Dr. C. F. Schram, Beloit.

10:45. Surgical Treatment of Hand Injuries.
Dr. T. S. O'Malley, Milwaukee.

11:10. Indications and Contraindications for Biopsy in Surgery.
Dr. P. F. Doege, Marshfield.

11:35. The Importance of Blood Grouping in Clinical and Legal Medicine.
Dr. Arthur A. Schaefer, Milwaukee.

ROOM C

10:20. Glioma Retinae (Neuroepithelioma): Report of a case. Lantern slides.
Dr. Richard C. Smith, Superior.

10:45. Orbital Inflammation Secondary to Sinus Infection.
Dr. John B. Hitz, Milwaukee.

11:10. Otitis Media and the Family Physician.
Dr. John P. Harkins, Madison.

11:35. Treatment of Nasal Polyps with Radium after Removal.
Dr. Walter A. Ford, Sheboygan.

1:30 P. M. GENERAL SESSION. GRAND BALL ROOM.

1:30. Splanchnic Manifestations of Psychoneurosis.
Dr. R. C. Blankinship, Madison.

1:50. The Clinical and Pathological Aspects of the Cancer Problem.
Dr. Max Cutler, Chicago.

2:20. Occult Syphilis: A Neglected Factor in Diagnosis and Treatment.
Dr. Udo Wile, Ann Arbor.

2:50. End Results of Cholecystectomy: Based on a study of six hundred cases.
Dr. Arnold Jackson, Madison.

3:10. Intestinal Obstruction: Application of Some of the Newer Principles Evolved from Experimental and Clinical Experience.
Dr. Edmund H. Mensing, Milwaukee.

3:30. Intermission.

3:40. Treatment of Burns.
Dr. Stanley Seeger, Milwaukee.

4:10. The Development of Medical Education in the United States.
Dr. C. R. Bardeen, Madison.

4:30. Oration in Surgery. Denervation of the Adrenal Glands.
Dr. Geo. W. Crile, Cleveland.

THURSDAY, SEPTEMBER 15

ROOM A

8:00. The Use of the Colloidal Phase in Urine for Diagnostic Purposes.
Dr. Frederick Eigenberger, Sheboygan.

8:25. The Physician of Yesterday, Today, and Tomorrow.
Dr. John F. Bennett, Burlington.

8:50. Treatment of Morphinism.
Dr. Merle Q. Howard, Wauwatosa.

9:15. Dermatology in General Practice.
Dr. L. M. Wieder, Milwaukee.

9:40. Intermission.

10:10. The Electrocardiogram in General Medicine.
Dr. Benjamin J. Birk, Milwaukee.

10:35. Addison's Disease.
Dr. R. B. Montgomery, La Valle.

11:00. Will Cretinism Become Endemic in Wisconsin?
Dr. Charles H. Stoddard, Milwaukee.

11:25. Differential Diagnosis of Hyperthyroidism and Neuroses.
Dr. A. L. Mayfield, Kenosha.

ROOM B

8:00. Interpretation of Roentgenograms of the Skull in Children.
Dr. Helen J. Zillmer, Milwaukee.

8:25. Convulsions in Children. Lantern slides and moving pictures.
Dr. M. G. Peterman, Milwaukee.

8:50. Measles Encephalitis.
Dr. Max Fox, Milwaukee.
Discussion: Dr. J. L. Garvey, Milwaukee.

9:15. Acute Anterior Poliomyelitis: A Pediatric Problem.
Dr. F. R. Janney, Milwaukee.

9:40. Intermission.

10:10. Upper Respiratory Infections in Children.
Dr. G. H. Fellman, Milwaukee.
Discussion: Dr. Ralph Sproule, Milwaukee—Complications in the ear and accessory sinuses. Dr. Roy M. Greenthal, Milwaukee—Complications involving the heart and lungs.

10:45. Congenital Syphilis.
Dr. R. P. Schowalter, Milwaukee.

11:10. Clinical Study of Vitamin D Milk. Its Use during Pregnancy as a Preventive of Rickets.
Dr. N. E. McBeath, Milwaukee, and Dr. H. O. McMahon, Milwaukee.

11:35. The Suitable Time for Surgery in Children.
Dr. Irwin Schultz, Milwaukee.

ROOM C

8:00. The Relative Position of the Radiologist in the Medical Profession.
Drs. L. V. Littig, J. N. Sisk, and E. A. Pohle, Madison.

8:50. Roentgen Therapy in Giant-Cell Tumor of Bone (with cases).
Dr. Barton W. Johnson, Fond du Lac.

9:15. Uterine Fibroids and Radium. (A resume of 370 cases).
Dr. Austin O. Olmsted, Green Bay.

9:40. Intermission.

10:10. Some Unusual Duodenal Pathology.
Dr. James A. Evans, La Crosse.

10:35. A Roentgenological Evaluation of Nervous Indigestion.
Dr. F. H. Kuegle, Janesville.

11:00. Roentgenology in the Diagnosis of Thoracic Lesions.
Dr. R. P. Potter, Marshfield.

11:25. Pulmonary Tuberculosis in Childhood.
Dr. S. M. Welsh, La Crosse.

12:00–2:00 P. M. ROUND TABLE LUNCHEONS.

1. Dr. O. R. Lillie, Milwaukee.
   Appendicitis.
2. Dr. Stanley Seeger, Milwaukee.
   Problems in Surgery. (To be announced.)
3. Dr. F. J. Gaenslen, Milwaukee.
   Fractures of the Foot and Ankle.
4. Dr. W. E. Grove, Milwaukee.
   Vasomotor or Hyperesthetic Rhinitis.
5. Dr. James C. Sargent, Milwaukee.
   Problems in Urology. (To be announced.)
6. Dr. J. L. Yates, Milwaukee.
   Surgery of Pulmonary Tuberculosis.
7. Dr. H. B. Podlasky, Milwaukee.
   Gall-Bladder Symposium.
8. Dr. Jos. Lettenberger, Milwaukee.
   Problems in Medicine. (To be announced.)
9. Dr. W. J. Egan, Milwaukee.
   Problems in Medicine. (To be announced.)
10. Dr. Karl Kassowitz, Milwaukee.
    Chronic Infections of the Lung in Childhood.
11. Dr. Carl Henry Davis, Milwaukee.
    Problems in Gynecology. (To be announced.)
12. Dr. Oscar Lotz, Milwaukee.
    Diseases of the Chest.

2:10 P. M. GENERAL SESSION. GRAND BALL ROOM.

2:10. President's Address.
Dr. Reginald Jackson, Madison.

2:35. Reducing Prescription Costs. Economies by Prescribing Standard Pharmaceuticals.
Mr. Herman L. Emmerich, President Wisconsin Pharmaceutical Association, Milwaukee.

3:05. The Dawn of a New Specialty in Medicine: Allergy.
Dr. W. W. Duke, Kansas City.

3:35. Intermission.

3:50. Observations on Some Abdominal Conditions in Childhood.
Dr. Samuel Amberg, Rochester, Minn.

4:10. Oration in Medicine. The Parathyroid Glands and their Relation to Calcium Metabolism.
Dr. David Barr, St. Louis.

7:00. GRAND BALL ROOM. ANNUAL DINNER. INFORMAL.
Speaker of the evening: Dr. Richard E. Scammon, Dean of Medical Sciences, University of Minnesota, Minneapolis. "The Foundation and Early History of St. Bartholomew's—the first Hospital in London."

FRIDAY, SEPTEMBER 16

ROOM A

8:00. Differentiation of Bronchial Asthma from the Paroxysmal Dyspnea of Cardiac Origin.
Dr. Herbert P. Benn, Stevens Point.

8:25. Malignant Conditions of the Lung.
Dr. William Jermain, Jr., Milwaukee.

8:50. Bronchoscopic Examination as an Aid in Obscure Pulmonary Conditions.
Dr. John S. Gordon, Milwaukee.

9:15. Asbestosis.
Dr. Ralph G. Mills, Fond du Lac.

9:40. Intermission.

ROOM B

8:00. Obstetrical Analgesia.
Dr. R. H. Ludden, Viroqua.

8:25. Prevertebral Abscesses. Case report with lantern slides.
Dr. F. C. Christensen, Racine.

8:50. Acute Abdominal Surgery from the Standpoint of the General Practitioner.
Dr. L. O. Simenstad, Osceola.

9:15. Diaphragmatic Hernia.
Dr. Robert Blumenthal, Milwaukee.

9:40. Intermission.

ROOM C

8:00. Roentgen Ray Exploration of the Pelvic Viscera with the Aid of Brominized Oil. Lantern slides.
Dr. Joseph J. Eisenberg, Milwaukee.

8:25. Eitology and Pathology of Renal Infections. (So-called "Surgical Kidney.")
Dr. William Carson, Milwaukee.

8:50. The Chronic Infected Prostate.
Dr. Cyril G. Richards, Kenosha.

9:15. Trans-Urethral Resection of Prostatic Obstruction.
Dr. James C. Sargent, Milwaukee.

9:40. Intermission.

10:00 A. M. GENERAL SESSION. GRAND BALL ROOM.

10:00. Report of Delegates to the American Medical Association; Report of House of Delegates.

10:25. The Effect on the Lungs of Fungus Spores Found in Maple Bark.
Dr. J. W. Towey, Powers, Mich.

10:45. Finding Tuberculosis in Apparently Healthy Youth.
Dr. A. A. Pleyte, Milwaukee.

11:05. The Leukopenic Syndrome.
Dr. Fred Madison, Milwaukee.

11:25. Leukopenia and Acute Leukemias with the Differential Diagnosis from Similar Blood Conditions.
Dr. Charles H. Watkins, Rochester, Minn.

1:40 P. M. GENERAL SESSION. GRAND BALL ROOM.

1:40. The Orthopedic Treatment of Infantile Paralysis.
Dr. Walter P. Blount, Milwaukee.

2:00. The Female Sex Hormone.
Dr. Elmer L. Sevringhaus, Madison.

2:20. The Clinical Significance of Recent Advances in Medical Science.
Dr. Wm. D. Stovall, Madison.

2:40. Injuries to the Heart and Aorta.
Dr. L. M. Warfield, Milwaukee.

3:10. The Treatment of Heart Disease.
Dr. Ellsworth S. Smith, St. Louis.

3:40. Clinical Aspects of Bright's Disease.
Dr. Francis D. Murphy, Milwaukee.

4:10. Etiology and Pathology of Nephritis.
Dr. E. T. Bell, Minneapolis.

4:40. Constitutional Factors in Disease.
Dr. Julius Bauer, Vienna, Austria.

SCIENTIFIC EXHIBITS

1. Milwaukee Health Department.
   Exhibit of material from the Milwaukee Health Department and other welfare and health organizations which won for Milwaukee first place in the National Inter-Chamber Health Conservation Contest.
2. Wisconsin Anti-Tuberculosis Association.
3. Muirdale Sanatorium.
4. Mount Sinai Hospital.
5. Chemical Laboratory of the American Medical Association.
   Posters and specimens bearing on the subject of newer synthetics, comparative prices of proprietary and nonproprietary remedies, and drug control.
6. Dr. A. Levinson, Chicago, Ill.
   Cerebrospinal fluid in health and disease. Exhibit consisting of charts and slides showing chemical and physicochemical studies of the spinal fluid; comparative studies of blood and of lumbar and cistern fluid in children; and cerebrospinal fluid changes in various conditions. The exhibit is designed to show the most recent investigations on cerebrospinal fluid.
7. Dr. M. G. Peterman, Milwaukee.
   Two motion pictures entitled "Convulsions in Infancy and Childhood" and "The More Common Dystrophies in Childhood." Charts, graphs, and photographs of interesting cases.
8. Dr. E. J. Carey, Milwaukee.
   Exhibit of models and charts illustrating the mechanical forces involved in movements and deformities of the spine.
9. Dr. S. M. Markson, Milwaukee.
   Exhibit of photographs illustrating unusual dermatoses.
10. Dr. F. D. Murphy, Milwaukee.
    Exhibit of pathological specimens illustrating the various types of kidney disease.
11. Dr. M. N. Federspiel, Milwaukee.
    Exhibit illustrating the various diseases and deformities encountered by the oral surgeon.
12. Moving picture.
    The Harvey Film on the Circulation of the Blood.
13. Exhibit on Poliomyelitis. Bureau of Exhibits, American Medical Association.

TECHNICAL EXHIBITS

Sixteen of the seventeen booths available have been reserved by technical exhibitors for the 91st anniversary meeting. The exhibits will occupy the hall opposite and adjacent to that in which the scientific sessions will be held. Among those who will exhibit at this meeting are:

Booth No.	*Exhibitor*
1	Medical Protective Company
2	Mead Johnson & Company
3	Mellin's Food Company
4	Victor Mueller Company
5	Scanlan–Morris Mfg. Company
6	E. H. Karrer Company
7	Roemer Drug Company
8	W. B. Saunders Company
9	Horlick's Malted Milk Corporation
10	H. G. Fischer & Co. Inc.
11	Kremers–Urban Company
12	
13	Merck & Company
14	Victor Hurley Company
15	DeVilbiss Company
16	General Foods Corporation
17	General Electric X-Ray Corporation

ENTERTAINMENT FOR LADIES

A special program of entertainment is being arranged for the entertainment of the wives of the members. While the plans are under the Auxiliary, it is stressed that the entertainment is for all visiting ladies. A complete program will be printed in full in the September Journal.

Members of the Auxiliary will hold one meeting for the transaction of business and the election of officers for the ensuing year. At this and other sessions the Wisconsin members will be host to Mrs. Walter Jackson Freeman, Philadelphia, President of the National Auxiliary and Mrs. James Blake of Hopkins, Minnesota, President-elect.

Entertainment for the ladies will be given on Wednesday and Thursday concluding with the annual dinner, informal, on Thursday evening following which there will be dancing and cards.

GOLF TOURNAMENT

The annual golf tournament of the State Society will be held on the course of the Tripoli Country Club on Tuesday, September 13th. Dr. Francis Thompson, Milwaukee, chairman of the Golf Committee urges

all golf enthusiasts to enter the tournament play. Prizes topped by the President's and Secretary's cups will be awarded at buffet supper following the afternoon play.

The Committee has laid plans for a real get together day and entry blanks will be mailed each member the latter part of August.

DELEGATES AND ALTERNATES WHO WILL COMPRISE 1932 HOUSE OF DELEGATES

Society	*Delegate*	*Alternate*
Ashland–B–I	J. W. Prentice, Ashland	J. M. Dodd, Ashland
Barron–W–S–B	J. H. Wallis, Rice Lake	S. O. Lund, Cumberland
Brown–Kewaunee	R. M. Carter, Green Bay	W. M. Wochos, Kewaunee
Calumet	J. W. Goggins, Chilton	F. P. Knauf, Kiel
Chippewa	W. C. Henske, Chippewa Falls	A. J. Somers, Chippewa Falls
Clark	H. H. Christofferson, Colby	R. H. Wink, Granton
Columbia	H. E. Gillette, Pardeeville	
Crawford	C. A. Armstrong, Prairie du Chien	J. J. Kane, Prairie du Chien
Dane	L. V. Littig, Madison	A. R. Tormey, Madison
	L. W. Peterson, Sun Prairie	Louis Fauerbach, Madison
Dodge	E. P. Webb, Beaver Dam	A. W. Hammond, Beaver Dam
Door	J. Hirschboeck, Forestville	
Douglas	T. J. O'Leary, Superior	C. W. Giesen, Superior
Eau Claire & Associated	F. C. Kinsman, Eau Claire	F. E. Butler, Menomonie
Fond du Lac	D. J. Twohig, Fond du Lac	
Grant	E. H. Spiegelberg, Boscobel	M. A. Bailey, Fennimore
Green	J. F. Mauermann, Monroe	W. G. Bear, Monroe
Green Lake–W–A	A. J. Wiesender, Berlin	G. E. Baldwin, Green Lake
Iowa	M. T. Erickson, Highland	M. W. Trentzsch, Highland
Jefferson	H. P. Bowen, Watertown	W. S. Waite, Watertown
Juneau	C. C. Vogel, Elroy	
Kenosha	G. F. Adams, Kenosha	
La Crosse	Gunnar Gundersen, La Crosse	R. E. Flynn, La Crosse
Lafayette	R. B. Quinn, Darlington	W. B. Williams, Argyle
Langlade	J. C. Wright, Antigo	J. W. Lambert, Antigo
Lincoln	E. O. Ravn, Merrill	K. A. Morris, Merrill
Manitowoc	R. W. Hammond, Manitowoc	Wm. Rauch, Valders
Marathon	R. W. Jones, Wausau	R. F. Fisher, Wausau
Marinette–Florence	G. R. Duer, Marinette	J. V. May, Marinette
Milwaukee	J. O. Dieterle, 425 E. Wis. Ave.	Oscar Lotz, 324 E. Wis. Ave.
	E. W. Miller, 231 W. Mich. St.	F. D. Murphy, 536 W. Wis. Ave.
	S. J. Seeger, 324 E. Wis. Ave.	H. G. Schumm, 425 E. Wis. Ave.
	H. J. Gramling, 2740 W. Forest Home	G. W. Neilson, 308 W. North Ave.
	H. W. Powers, 161 W. Wis. Ave.	R. E. Fitzgerald, 2750 N. Teutonia Ave.
	C. J. Coffey, 231 W. Wis. Ave.	F. J. Gaenslen, 425 E. Wis. Ave.
	A. A. Pleyte, 1018 N. Jefferson St.	M. Tufts, 208 E. Wis. Ave.
	S. G. Higgins, 324 E. Wis. Ave.	N. E. McBeath, 425 E. Wis. Ave.
	M. G. Peterman, 707 N. 17th St.	Lucius Hipke, 425 E. Wis. Ave.
	B. Krueger, Cudahy	Wm. Jermain, 1705 W. Wis. Ave.
	F. A. Thompson, 735 N. Water St.	S. H. Lippitt, 425 E. Wis. Ave.
	D. E. W. Wenstrand, 720 E. Wis. Ave.	R. A. Toepfer, 5819 W. Nat'l Ave.
	Edith McCann, 425 E. Wis. Ave.	U. A. Schlueter, 408 W. Greenfield Ave.
Monroe	A. R. Bell, Tomah	C. H. Cremer, Cashton
Oconto	W. R. Berg, Gillett	J. S. Dougherty, Suring
Oneida–F–V	I. E. Schiek, Rhinelander	
Outagamie	C. D. Boyd, Kaukauna	C. D. Neidhold, Appleton
Pierce–St. Croix	A. E. McMahon, Glenwood City	Rolla Cairns, River Falls
Polk	R. G. Arveson, Frederic	J. D. Nicholson, Milltown
Portage	E. P. Crosby, Stevens Point	E. E. Kidder, Stevens Point
Price–Taylor	G. E. MacKinnon, Prentice	
Racine	H. B. Keland, Racine	L. E. Fazen, Racine
Richland	George Parke, Viola	B. I. Pippin, Richland Center
Rock	W. J. Allen, Beloit	P. A. Fox, Beloit
Sauk	H. J. Irwin, Baraboo	Edw. McGrath, Baraboo
Shawano	A. J. Gates, Tigerton	C. E. Stubenvoll, Shawano
Sheboygan	R. C. Meyer, Plymouth	C. J. Weber, Sheboygan
Trempealeau–J–B	C. F. Peterson, Independence	H. A. Jegi, Galesville
Vernon	W. H. Remer, Chaseburg	John Schee, Westby
Walworth	R. C. Halsey, Lake Geneva	T. L. Jacobson, Delavan
Washington–Ozaukee	H. M. Lynch, West Bend	N. E. Hausmann, Kewaskum
Waukesha	H. T. Barnes, Delafield	H. A. Peters, Oconomowoc
Waupaca	W. Irvine, Sr., Manawa	E. H. Jones, Weyauwega
Winnebago	J. W. Lockhart, Oshkosh	R. B. Rogers, Neenah
Wood	F. X. Pomainville, Wis. Rapids	K. H. Doege, Marshfield

House of Delegates Holds First Session Tuesday Evening, Sept. 13th

Calling attention to the fact that the first session of the House of Delegates will be held at the Schroeder Hotel, Milwaukee, beginning at seven Tuesday evening, September 13th, a letter from the Secretary has been forwarded all delegates and alternates explaining the basic procedures of the House. The letter follows in part:

"The sessions of the House this year beginning Tuesday evening, September 13th, promise to be of such major importance that your Secretary takes this opportunity to call your attention to the reports and methods of procedure.

"The reports published in the August Journal should be read by every delegate and alternate. Note particularly the recommendations of the committees upon which the House will be called to act. Two special reports are being mailed you. Bring these to the meeting with you.

"When the House is called to order Speaker Stanley J. Seeger will appoint from among you four reference committees of the House. The first is on Credentials, the second on Resolutions, the third on Reports of Officers and the fourth on Reports of Standing Committees. These committees will all report on Wednesday evening at which time the reports will be before the House for final action.

"All intended resolutions should be introduced on Tuesday evening, the first session, and should be typewritten *in triplicate.*

"Elections of the following will be held Tuesday evening:

Councilors:

Seventh District—To succeed Spencer D. Beebe, Sparta, term expires.

Eighth District—To succeed T. J. Redelings, Marinette, term expires.

Ninth District—To succeed Joseph F. Smith, Wausau, term expires.

Tenth District—To succeed H. M. Stang, Eau Claire, term expires.

Delegates to A. M. A.:

1. To succeed J. Gurney Taylor, Milwaukee, term expires.
2. To succeed W. E. Bannen, La Crosse, term expires.

Alternates to A. M. A.:

1. To succeed F. Gregory Connell, Oshkosh, term expires.
2. To succeed T. W. Nuzum, Janesville, term expires.

"Nominations for councilors must come in the first instance from delegates residing in the districts affected. Thus delegates in the Seventh District (La Crosse; Vernon; Trempealeau–Jackson–Buffalo; Monroe; Juneau counties) caucus and nominate their councilor.

"One or more nominations for the offices of President-Elect, Speaker of the House and Vice-Speaker of the House are presented by the Committee on Nominations at the Thursday afternoon session. This Committee is selected on Tuesday night in the following manner: The Secretary reads the list of societies in the first district and as he reads the list the delegates from those counties rise and remain standing. At the conclusion of the reading the delegates nominate from among themselves one delegate to represent that district on the committee on Nominations. Similar procedure is followed for the other districts. This method insures a representative committee. Nominations of the committee do not preclude additional nominations from the floor of the House.

"Your Speaker and Secretary have made every effort to expedite the handling of the mass of business that must come before the sessions of the House. Delegates and alternates should keep in mind, however, that *the floor is open* to them *at all times.* A full discussion is needed if the House is to accomplish the best results in interest of the profession of the state. Just because you may happen to be a new delegate, do not feel that you must remain silent. All delegates are striving to attain the same ends and each discussion is welcomed.

"A word to the alternates: It has been the custom to open the floor to you for any discussions you may wish to make. You will not vote, however, if your delegate is present at the time the vote is taken. For this reason it is well for delegate and alternate to sit together so that the alternate may be apprised should the delegate leave the meeting.

"All members of the Society are welcome to attend the sessions of the House. A member, not a delegate or alternate, may address the House by notifying the Secretary or the Speaker of the House of his desires previous to or during the sessions."

SPECIAL REPORTS ISSUED

Each delegate, alternate and officer of the State Society was mailed a copy of the 28 page report of the Special Committee on the Distribution of Medical Services the last week in July. This report of the ten months effort of the Committee is entitled a progress report and will not be distributed generally until after the House of Delegates has acted upon it at the September meeting.

The report of the Special Committee to Investigate Admissions at the Wisconsin General Hospital is presently completing its report. This report will likewise be mailed delegates, alternates and officers direct and it is expected that it will be in the mails by August tenth.

Delegates and alternates are urged to bring both of these reports to the meetings of the House to facilitate ready reference during the discussions.

Reports of Officers and Committees to House of Delegates

CHAIRMAN OF THE COUNCIL

To the 1932 House of Delegates:

Acting under your authorizations, your Council each year is charged with the duty of apportioning the income of the Society that we may secure through wise expenditures those accomplishments outlined as your desires. As was stated a year ago, the measurement of a Secretary and his office staff of three must not be concerned with their value in maintaining records, handling correspondence, and editing and supervising the monthly issue of our Journal but upon their productive value in securing the ends you desire through their personal services. The current year has again given us proof of this statement amply evidenced in the report of the Secretary and the several committees for whom the office staff has been the executive force.

Cognizant of the fact that your Society will prosper and achieve only as it is representative of the considerate thought of the general membership, the Secretary has again prepared an itemized statement of the budget that each member may know in some detail of the expenditures of the Society. This budget is first prepared in the late fall by a Budget Committee and is then subject to Council action in January before final approval is granted. The budget for the current year follows:

Salaries	Total	Amount per member
J. G. Crownhart, Secretary–Managing Editor*	$6,800	$3.67½
Ruth Buellesbach, assistant	2,100	1.13½
Florence Ripley, in charge of records, mailing and proofreading	1,700	.92
Ellinore Beck, stenographer and in charge of subject and investigation files	1,700	.92
Rent	900	.49
Supplies including printing, postage, telephone, light, telegraph, office supplies, etc.	2,400	1.30
Press Service—furnishing a weekly article on the advances and facilities of medicine to all weekly and daily papers of the state	2,200	1.19
Travel of the Secretary and assistant	1,000	.54
Special Committee on the Distribution of Medical Services in Wisconsin	1,800	.97
Editorial Board—Appropriation to meet $900 anticipated loss in advertising and $600 honorarium for Medical Editor	1,500	.81
Annual Meeting—Appropriation in excess of $1400 exhibit revenue	1,800	.97
Foundation Fund—Special appropriation to complete legal work in perfecting this trust	250	.13
Public Policy, Committee on——For work of this committee in preparing bulletin on poor relief laws and preparatory to legislative session	500	.27
Hygeia — Presenting annual subscriptions to state officers, legislators, editors, and prominent and interested laymen	500	.27
Delegates to A. M. A.—Rail and pullman fare for three delegates to New Orleans	360	.20
Secretaries' Conference—Cost of stenotype reporter and expenses out-of-state speakers at time of annual meeting	300	.16
Legal—expense incurred in securing information for general membership on matters affecting entire profession, see report of Secretary	600	.32
Committees—expense of committee members in attending meetings, rail and pullman, meals at committee sessions and rail expense of Councilors in attending extra session	750	.41
County Constitutions—appropriation to provide legal assistance in perfecting a revision and costs of publication	100	.05
Special Committee to Investigate Admissions at Wisconsin General Hospital	500	.27
	$27,760	$15.00

* The Secretary receives $1200 from the Journal which has been self-supporting to this year. His total salary is $8,000 as last set in January, 1930.

It is to be noted that in the preparation of this Budget your Council effected the following economies in similar services of a year ago: Rent $240; Press Service $550; Editorial Board $1,000 and Secretaries' Conference $500. It appears that current income of the year will be sufficient to balance this budget and to meet any incidental items that may arise in the next six months. It does not appear that the income will be more than sufficient.

RESERVE

At your session ten years ago it was your decision to increase your dues from $4 to $9 to permit the employment of a full-time lay Secretary–Managing Editor. At that time your Society had no reserves and was, in fact, meeting November bills from the next January receipts. In an organization charged with such duties and whose work was of such importance to the economic stability of the profession, it was thought fitting that the Society should have a reasonable surplus. Through the ten-year period this surplus has reached the sum of $25,000, something less than the budget of the Society for a single year. This surplus of $25,000 is comparable to those of $110,000 in Illinois; $50,000 in Michigan, $32,000 in Iowa, $25,000 in Minnesota and $30,000 in Indiana. It is not the intention or desire of your officers to increase the present amount except by such small margins as good business judgment in-

dicates as essential in framing the annual budget to avoid loss.

SPECIAL COMMITTEES

During the current year your Council has created two special committees to carry on special work of the Society. The first of these is one to discuss with officers of the Wisconsin Anti-Tuberculosis Association joint problems of the Association and profession. The members of this committee are Drs. J. Francis Wilkinson, Oconomowoc, Chairman; Wilson Cunningham, Platteville and H. M. Stang of Eau Claire.

At its April meeting, the Secretary reported on various proposals from the membership concerning admissions to the Wisconsin General Hospital. To complete the survey of admissions and investigate complaints from the membership, the Council authorized its second special committee composed of Drs. Reginald Jackson, Madison, President-elect, Chairman; F. W. Pope, Racine, and S. E. Gavin of Fond du Lac. This latter committee is directed to report its findings to this House of Delegates.

COMMITTEE ON CANCER

Following a survey of Wisconsin as to its cancer problems, it seemed advisable to the Council that we have a permanent committee to treat with that subject matter. Such a committee was accordingly authorized and appointed representing each councilor district. Hereafter the incoming president will name four of the twelve members each year of the committee.

CARE OF VETERANS

President Fiedler has given greatly of his time as a member of the Legislative Committee of the American Medical Association and has made great study of this subject. The Secretary completed a survey of the situation with respect to hospital care in our own state in the late spring. It would appear that due to the excellence of the work of the President that the Legion in Wisconsin will declare for the Shoulders plan as a progressive step in the interest of the proper care of the veterans of our World War.

MISCELLANEOUS

Your Council has been called to pass upon many miscellaneous matters during the year which have been reported fully in the columns of the Wisconsin Medical Journal. Some of the more important of these include fees for accidents of industry, care of the indigent, standing orders for nurses in industry and automobile accidents in their relation to the suggested lien law. This work of the Council will be reported to you under the work of the appropriate committees.

DEATH OF DR. EVANS

Your Chairman has the sad duty of calling to your attention the death during the year of Dr. Edward Evans, twenty-two years a member of the Council and for twelve years its Chairman. We record his passing with a deep appreciation of his loyal and fine services to this Society through his long years in this body.

SUMMARY

Your Special Committee on Distribution of Medical Services will tell you that the annual cash income of the profession of this state is estimated to be in the neighborhood of nineteen millions of dollars. Our annual budget to do all of the work of the Society including that to protect our membership against impositions and injustice is but $28,000. So long as this income is used wisely and the activities of your Society are carried on efficiently, certainly it would not appear that our budget of one and one-half one thousandth of our income is excessive. On the contrary it seems to be a very small amount.

The Councilors of your Society are in effect your trustees. It is a rare month that does not find them called upon to pass on important questions and, with the added spring meeting, more than ever are they called to give generously of their time and efforts in your interest.

Respectfully submitted,

Arthur W. Rogers,
Chairman of the Council.

REPORT OF THE SECRETARY–MANAGING EDITOR

To the 1932 House of Delegates:

Due to the early publication requirement of the Journal, the membership report of your Society for the current year must be published as of July first. A revised report will be made to the House when it meets on September thirteenth.

At the close of the first six months the membership was 1731. Those in arrears numbered 426. It was the opinion of the Council that the membership for the year would approximate 1800. It is apparent that this estimate will be exceeded and it is believed that the figures for the complete year will compare favorably with those in our neighboring states.

The membership data by Councilor districts follows:

MEMBERSHIP REPORT

July 1, 1932

County Society	Last Year	This Year	Loss— Gain+	Delinquent	Deceased	Removed	New Members	Honorary
1st District—								
Dodge	23	21	— 2	3	--	1	2	--
Jefferson	30	27	— 3	4	--	--	1	--
Waukesha	49	44	— 5	8	--	--	3	1
Totals	102	92	—10	15	--	1	6	1

County Society	Last Year	This Year	Loss— Gain+	Delinquent	Deceased	Removed	New Members	Honorary
2nd District—								
Kenosha	38	36	— 2	6	--	1	5	--
Racine	65	58	— 7	7	1	3	4	--
Walworth	28	21	— 7	8	--	--	1	1
Totals	131	115	—16	21	1	4	10	1
3rd District—								
Dane	167	131	—36	35	3	1	3	3
Columbia	30	27	— 3	5	--	--	2	--
Green	18	22	+ 4	--	--	2	6	--
Rock	77	46	—31	30	1	2	2	--
Sauk	19	13	— 6	6	--	--	--	--
Totals	311	239	—72	76	4	5	13	3
4th District—								
Crawford	7	8	+ 1	--	--	--	1	--
Grant	33	32	— 1	--	1	2	2	--
Iowa	13	9	— 4	4	--	--	--	--
Lafayette	10	7	— 3	3	--	--	--	--
Richland	13	10	— 3	2	1	1	1	--
Totals	76	66	—10	9	2	3	4	--
5th District—								
Calumet	14	9	— 5	5	--	--	--	--
Manitowoc	37	27	—10	8	2	--	--	1
Sheboygan	54	50	— 4	3	1	1	1	--
Washington-Ozaukee	27	15	—12	12	--	--	--	--
Totals	132	101	—31	28	3	1	1	1
6th District—								
Brown-Kewaunee	64	53	—11	13	--	--	2	--
Door	5	3	— 2	3	--	--	1	--
Outagamie	41	38	— 3	5	1	1	4	--
Fond du Lac	48	48	--	3	--	--	3	
Winnebago	59	54	— 5	6	1	--	2	--
Totals	217	196	—21	30	2	1	12	--
7th District—								
Juneau	7	6	— 1	1	--	--	--	--
La Crosse	53	44	— 9	8	1	1	1	2
Monroe	17	13	— 4	4	--	--	--	--
Trempealeau-J-B	20	22	+ 2	--	--	--	2	--
Vernon	10	8	— 2	2	--	--	--	--
Totals	107	93	—14	15	1	1	3	2
8th District—								
Marinette-Florence	20	17	— 3	2	--	1	--	--
Oconto	8	7	— 1	2	--	--	1	--
Shawano	11	11	--	--	--	--	--	--
Totals	39	35	— 4	4	--	1	1	--
9th District—								
Clark	17	10	— 7	7	--	--	--	--
Green Lake-W-A	16	10	— 6	2	1	4	1	--
Lincoln	13	12	— 1	1	--	--	--	--
Marathon	39	34	— 5	6	--	--	1	--
Portage	23	20	— 3	2	1	--	--	--
Waupaca	16	13	— 3	3	--	--	--	1
Wood	29	28	— 1	1	2	1	3	--
Totals	153	127	—26	22	4	5	5	1
10th District—								
Barron-W-S-B	26	23	— 3	4	--	--	1	--
Polk	13	15	+ 2	--	--	--	2	--
Chippewa	24	20	— 4	3	1	1	1	1
Eau Claire & Assoc.	59	51	— 8	8	--	--	--	--
Pierce-St. Croix	25	19	— 6	6	--	--	--	--
Totals	147	128	—19	21	1	1	4	1
11th District—								
Ashland-B-I	22	16	— 6	6	--	--	--	--
Douglas	35	20	—15	15	--	--	--	--
Langlade	13	11	— 2	2	--	--	--	--
Oneida-F-V	12	10	— 2	2	--	--	--	--
Price-Taylor	9	4	— 5	5	--	--	--	--
Totals	91	61	—30	30	--	--	--	--
12th District—								
Milwaukee	638	487	—151	155	2	8	14	--
Gr. Total	2144	1740	—404	426	20	31	73	10

GENERAL DUTIES

As Secretary of the Society, your Secretary also acts in that capacity for each of the Society's committees. While these duties are always comprehensive, this year necessitated the additional work of compiling all the many studies for the Special Committee on Distribution of Medical Services. This work has been continuous since November, 1931 and

has demanded of the utmost in time and energy of the entire office staff that the Committee report might be ready for the 1932 House of Delegates.

Studies made under the Committee's direction through your central office include:

Distribution of physicians and hospitals, income of residents by counties, incomes and expenses of physicians by cities and counties, cost of hospital construction in Wisconsin, indebtedness of hospitals in Wisconsin, care of veterans in Wisconsin hospitals, hospital staffs; open or closed, open or closed to rural practitioners, and qualifications for, care of the indigent, charity work, services of the state, services of state wide lay organizations, costs of illness, distribution of costs, contract practice, and others.

SCIENTIFIC WORK

As Secretary of the Advisory Committee on Medical Extension, your Secretary is happy to report the ability to secure an annual appropriation of $500 a year from the State Emergency Board which appears to be sufficient, with the generous aid of Dean Bardeen, to tide over the Medical Library Service until further appropriations may be secured from the 1933 legislature. It is to be noted that while a similar department of the American Medical Association filled 2,450 requests throughout the nation during 1931, in Wisconsin this service established at the University at the instance of your Society filled upwards of 4,425 requests in the same year. Letters continue to be received from members in almost every county in the state commending the work, urging its development and stating that it is one of the most valuable contributions of the Society and University in the field of scientific work. The Medical School deserves our hearty commendation for its willingness to assume the very considerable effort and financial burden that alone has made of this department such a valuable service to our membership. Any similar service on a commercial basis would equal the cost of membership dues.

Monthly bulletins to society officers have continued to bring to their attention program material of recognized worth available for society programs. Perusal of annual meeting program indicates that the Committee on Scientific Work has continued and enlarged upon the definite policy to make the state meeting a forum for the presentation of the scientific accomplishments of our own membership, as well as of those of invited guest speakers.

Your Secretary takes this opportunity to express his appreciation to Dean B. F. McGrath of Marquette for his efforts which resulted in furnishing county officers with a rather comprehensive list of speakers and subject matter available from the professorial staff of that University.

The central office has endeavored to be of every possible service to the Extension Division in the planning and accomplishment of successful postgraduate courses for the summer months. While the courses are limited by our ability to secure lecturers of the type essential to success, the work has gone forward steadily and two such courses are under way at the present time. Two other postgraduate courses were given at Madison during the spring.

The report on the work of the Medical Editor for the Journal will be found under the report of the Editorial Board.

THE JOURNAL

While the Journal has been self-supporting over a period of five years, the presently decreased advertising has made it impossible to maintain this record currently. The Journal has not reduced those legitimate expenses attendant upon the publication of the best possible scientific material, though every other economy has been made. A financial report for the calendar year of 1931 was published in the May Journal.

It is to be noted that the Journal has continued to carry, in addition to the scientific sections, other articles of value to the reader in acquainting him with progress in the many fields allied to the practice of medicine. Favorable comments from members on this section of the Journal have been many and valued.

For six years the exchange advertising columns have been open to the members without charge. This policy will be continued.

LEGISLATURE

A special session of the legislature was held during the winter months. Physicians were particularly concerned in the measure proposing an eight hour day. While the Interim Committee accepted the recommendation of your Secretary (acting in his joint capacity as Secretary of both your Society and the Wisconsin Hospital Association) that the single exemption to the measure be one to exempt hospitals, amendments to include hospitals were almost without number.

We were able to point out, after detailed studies, that the inclusion of hospitals would add upwards of $600,000 a year to the costs of illness. Already staggering under a burdensome debt, faced with caring for a steadily increased load of the indigent and deprived of large sources from which charitable funds previously had been available, it was evident that the hospitals would be totally unable and unprepared to handle this further load. Necessarily that would mean adding the increased cost of the law to the bill of the pay patient and thus the burden would eventually fall upon the sick at a time when they could least afford to pay the costs. That physicians would in turn bear the larger part of this burden was self-evident. We are happy to report that such inclusive legislation was not adopted and that the Interim Committee's favorable recommendation will be a powerful argument in favor of exemption when this legislation is represented presumably in the 1933 and subsequent sessions.

LEGAL SERVICES

Of the foremost importance in this field is the Summary of Poor Relief Laws Affecting Care of the Indigent Sick. This 16 page leaflet was designed to meet a condition that had hampered physicians in every part of the State from securing a proper or speedy relief of the indigent sick to whom they were called to render service.

This leaflet was sent to every member outside of Milwaukee county, in which county the leaflet was not applicable because of local rulings and institutions. Prepared to furnish 2,000 additional copies without charge for the information of local officers charged with handling relief of the poor, the requests came in such volumn as to necessitate a second edition of 1,000 copies. It now appears that a third edition may be essential. Letters from physicians and public officials alike have given high praise to this publication which was approved by the Attorney General of the State.

For several years it has been the policy of your Society to provide legal information to members where the question presented could be said to be of interest and value to all members as relates to the practice of medicine. During the year many of these opinions have been published in the Journal and include many questions relating to poor relief, use of title "Doctor", fees of an assistant surgeon, liability of third party for costs of medical service, statute of limitations with respect to malpractice action brought by a minor, liability of nurse as assistant to physician, liability for overt acts of a nurse in industry, liability for overdose, fees for expert testimony, practices under Workmen's Compensation Act, expulsion of member, several relating to the corporate practice of medicine and others of like nature. The files on these opinions rendered in past years are becoming exceedingly useful and increasingly of value.

Under this title may also be mentioned the studies made through this office with respect to collection agencies. A large information file has been accumulated and two warnings were sent each member during the year with respect to the deceptive contracts of many of these agencies. The Society will analyze any contract of this nature and give an immediate report on its nature and, insofar as possible, on the standing of the agency itself. Nearly a hundred members have taken advantage of this service during the year and the warnings have undoubtedly saved other members considerable amounts of money.

Upon approval of legal counsel, warnings were also issued to the general membership and society officers on the questionable practices of some insurance carriers in their efforts to secure agreements from members to reduce fees for compensation cases to an entirely unwarranted extent by misleading statements.

INCOME TAX DEDUCTIONS

For the seventh year, members were each sent a special leaflet describing in detail the deductions and depreciations peculiar to professional men, that might be taken on state and federal income tax returns. This leaflet represents a large amount of work that physicians may be kept abreast with every ruling. Two items added in 1932 to the state decisions relative to the deductibility of expenses for attendance at medical conventions and subscriptions to medical journals represent large and legitimate savings to the membership as a whole.

RADIO AND PRESS

Through the central office of your Society manuscripts were prepared for 105 radio talks presented by Miss Buellesbach over radio station WHA (University of Wisconsin). A number of these five and ten minute addresses were also radiocast over station WIBA at Madison. That the material is well prepared is evidenced by the fact that several have been used by the American Medical Association.

That the talks so prepared may be made as useful as possible, letters were addressed to the Secretaries of all component societies whose territory embraced local radio stations, suggesting that arrangements be made that a local health officer, or other suitable individual, present these talks locally under the auspices of the local societies. Stevens Point and Sheboygan are making such present use of copies of these manuscripts prepared in the central office. It is hoped that arrangements may be made in other cities having local radio service. (For titles of talks see report of Committee on Health and Public Instruction).

On a voluntarily reduced budget the Press Service of your Society has been continued during the year and now reaches nearly all of the daily and weekly newspapers of the state. Your Secretary believes that this effort has done more than possibly any other single endeavor to bring to hundreds of thousands of readers information, accurate as to detail, relating to the causes, means of relief, and prevention of disease. It is truly a public service that has gone far as an educational project reflecting to the benefit of your organization in the public opinion. (For list of subjects see report of Committee on Health and Public Instruction).

WISCONSIN HOSPITAL ASSOCIATION

By permission of the Council your Secretary is now in his second year as the elected Secretary of the Wisconsin Hospital Association, serving without compensation. The purpose of this affiliation is so to join the common interests of the two Societies that they may secure the advantages accruing out of joint effort. The value of this association was evidenced during the year in the survey on care of veterans and room available in local hospitals, in the survey on hospital practices and that on the costs of hospitalization.

NURSES IN INDUSTRY

Under the auspices of a special committee appointed a year ago, a suggested set of standing or-

ders for nurses employed in industry has been published with approval of the Council. The orders followed the plan of those issued by the Society and State Board of Health some years ago for nurses engaged in public health endeavor. A copy of the orders with a personal letter was sent from the central office to all nurses so employed. A few weeks later one violation was called to the attention of your Secretary. Upon our recommendation a letter containing a severe reprimand was issued the nurse involved by the State Health Officer and a copy, with identification deleted, was sent each nurse in similar employment calling attention to the seriousness of attempting to follow her own judgment, —in the instant case the result being the loss of an eye.

The nurses in industry have shown a cooperative spirit on several occasions, notably in the legislature, and it is anticipated that the committee's work, to be revised from time to time in the future, will go far to protect and promote the joint interest of the injured workman, the employer, and the professions. As was noted in our July Journal, this pioneer work of your Society has attracted national attention and commendation.

PLACEMENT SERVICE

For several years your Secretary has pursued the policy of addressing a personal letter to each new licentiate in this state. This letter contains our welcome, an expression of our desire to have him as a guest at the next meeting of the county society within whose jurisdiction he will reside, and application blank for membership, and our offer to be of every possible service in assisting him to select his location for Wisconsin practice. We have been of the opinion that this was a service not only to the licentiate but to the members as well. Our surveys have afforded us rather accurate data with respect to practically every community in the state. We are thus in position to advise against location where another physician will simply mean a cut income for those presently located to the extent that none are able to eke out more than a bare living. From the viewpoint of the public we are frequently able to suggest unopposed locations where the need for a physician is real. These services are also available to our entire membership.

Each year has seen an increase in the use of your central office in this manner. It appears to have become a valued and worthwhile endeavor, and particularly so at this time.

SERVICE TO ESTATES

So soon as notice is received of the death of a member, a personal letter is addressed to the widow warning against the unscrupulous methods pursued by some concerns with reference to collecting the accounts of the deceased. It is suggested that she consult a local attorney before signing any such contract. She is also advised that the advertising columns of the Journal are open without charge and that the central office stands ready to perform any other service that will be helpful. Executors of estates have written rather frequently to advise us that such letters had been a real service.

A. M. A. IN MILWAUKEE

Your Secretary is particularly pleased to announce that the American Medical Association has accepted the invitation of your Society and that of the Medical Society of Milwaukee County to hold its 1933 meeting in Milwaukee. In accordance with action in 1931, your Society will confine its 1933 meeting to sessions of the House of Delegates in Milwaukee at the time of the A. M. A. meeting.

COUNTY CONSTITUTIONS

A study of model constitution and by-laws for the component societies is now under way that a revised copy may be placed before you shortly for consideration of the several societies. The last edition was in 1913 and since that date many new situations have arisen that are not met with sufficient clarity or force under the old model.

AMENDMENT TO THE CONSTITUTION

At the 1931 meeting Dr. Spencer D. Beebe, Councilor of the 7th District, gave notice of an amendment to the Constitution to provide that Councilors, at present voting members of the House of Delegates, should be ex-officio members of the House with privileges of the floor but without the right to vote. This amendment has lain on the table one year and having been twice published in the Wisconsin Medical Journal, is properly before the 1932 House for action. No other amendments to the Constitution are presently before the House.

OFFICE STAFF

The work of your State office during the current year would have been impossible of execution without the able and efficient services of Miss Florence Ripley, in charge of proof and membership records; Miss Ellinore Beck, in charge of make-up of the Journal, subject and investigation files and stenographic assistant, and Miss Ruth Buellesbach, assistant to your Secretary. This small staff may not be decreased to advantage if it is your wish that the work of the Secretary as herein outlined be continued during the coming year.

TRAVEL

The current year has necessitated the Secretary remaining at Madison as much as possible because of the Special Session of the Legislature and to accomplish the numerous and detailed studies of the Special Committee on Distribution of Medical Services. Nevertheless the Secretary has visited the following societies: Dane, Milwaukee, Juneau, Barron–Washburn, Sawyer–Burnett, Polk, Rock and the Sixth District. He has also attended the Congress on Medical Education, Hospitals and Licensure, the Wisconsin–Illinois–Iowa Hospital Association, and

the Annual Conference of State Secretaries all at Chicago; the Northwest Regional Conference at St. Paul, the special meeting of the Michigan Society on Medical Economics at Jackson, and nineteen committees and council meetings held in Madison and Milwaukee in addition to that travel necessitated by current business of the Society.

DUES

No one appreciates more keenly than your Secretary, who has just finished the study of current incomes, that in this period of economic pressure the general membership will welcome extraordinary efforts in their behalf the result of which will be either to lower their expenses or increase their income. It is proper that the House give this its close attention.

It is self-evident that the very period that increases our economic pressure brings to the profession problems of still greater importance and urgency. Particularly may these be anticipated during the coming months of the legislative session. Detailed data on just what may be expected in activities at several levels of income will be presented by the Secretary to the proper reference committee of your House for their recommendations and subsequent action by the entire House. No substantial reductions are possible without corresponding retrenchment in the work undertaken. Whether the greater economy will be represented in a material reduction in dues or in maintaining the present level to bring continued dividends through fairly anticipated accomplishments, is a question your House must determine.

CONCLUSION

Your Secretary is deeply conscious that whatever accomplishments he is able to report have been made possible by the splendid degree of cooperation given by every member and officer, and the inspiration which alone can come from the knowledge that the Society membership is ever ready to render wholeheartedly that counsel and support so essential to the success of a state-wide program. As the tenth annual report of your Secretary, he takes the occasion to repeat in the words of his first report "that he has put one aim—to be of service to the members of this Society. He is a contact point between the members of the profession and the public and no matter in what part of this state you may reside, he is your Secretary. To best accomplish your aims he asks for your suggestions and criticisms at all times."

Respectfully submitted,

J. G. CROWNHART.

REPORT OF THE COMMITTEE ON PUBLIC POLICY

To the 1932 House of Delegates:

This Committee has had two meetings during the year and maintained a continuous contact in the study of questions before the Committee by means of constant correspondence. At the last meeting of the Committee in May, an entire Sunday was devoted to discussing the legislative questions before the Society and to conferences with representatives of other societies on like subject matter.

The following recommendations to the House come to you from our Committee for your consideration at this session:

1. The House of Delegates has ever favored the Committee by granting it permission to use its broad discretion in framing the final and actual legislative program in its entirety that it may represent those projects outstanding in the public interest and that it may not be overburdened at any single session. This Committee would respectfully ask continuance of this authority for the identical purposes.

2. This Committee announces that unless the House otherwise directs, the Committee will oppose in the name of the Society the following suggestions which have originated with groups who are anxious to secure legislation for the profit that it will bring to them:

a. Legislation which will in any manner curb vivisection as a means of scientific research at scientific institutions.

b. The Wisconsin Supreme Court has recently upheld the law providing that only those licensed to practice medicine or medicine and surgery may use the prefix "Dr." We will oppose legislation sought by chiropractors looking to granting them the use of this title.

c. We will oppose any change in the Basic Science law.

d. We will oppose any change in the law which would permit chiropractors to attend cases of contagious and communicable diseases.

e. We will oppose the suggestion that chiropractors be granted the right to treat the sick in the state and county hospitals and institutions.

f. We will oppose the suggestion that chiropractors be granted the right to treat the injured under the Workmen's Compensation Act.

g. Convinced that Federal subsidies in the field of promoting the public health means surrender of the state's right to direct health movements in such ways as may seem proper to the local State Board of Health and for the reason that past experience does not indicate that such Federal subsidies worked to the advantage of the citizens of the state, we will oppose any proposals in that direction. The purchase price of gifts by subsidy is the surrender of rights of direction to a master.

h. Appreciative that centralized care of the state's wards is sometimes indicated we feel that no condition presently exists which calls for extension of the state's resources for such care other than presently in the field for caring for the insane and feeble-minded and we will accordingly oppose entering extension of present facilities.

3. The Committee requests authority to ask for the adoption of a law which will better assure a rea-

sonable degree of compensation for hospital, physician, and nurse in automobile accident cases.

4. Poor Relief. While this entire subject matter will be made the subject of intensive study between now and the time the legislature meets, the Committee has two recommendations for your present consideration:

a. That in event of a medical or surgical emergency the physician may go ahead without waiting for authority and that his services will be automatically approved for the first seventy-two hours providing that services beyond seventy-two hours must receive approval from the proper poor relief authorities.

b. That in event that poor relief authorities refuse to authorize care for the indigent in any given case, the physician shall be entitled to recover from the proper unit of government upon petition of proof that the patient was in fact entitled to such relief.

5. The Committee requests authority to make some minor changes in those sections of the statutes governing the procedure of the State Society to the end that some ambiguous wording may be made clear and forceful to correspond precisely with the present procedures of this Society.

6. Of the 955,869 hospital beds in continental America, 63.8 per cent, or 609,844, are federal, state, county, or city institutions, and practically free to the patients. In the State of Wisconsin practically the same percentage is obtained. Approximately two thirds of the hospital beds in this State are free to the public.

The United States government, at the conclusion of the War, entered upon an extensive program of hospitalization of ex-service men. At first this service was limited to those having service connected disabilities. Later a group of patients suffering from either neuropsychosis, tuberculosis, encephalitis, amebic dysentery, or poliomyelitis, were considered to have service connected disabilities and were so treated. Recently all available beds in veterans hospitals were thrown open to any ex-service man with a disability requiring hospitalization.

The profession, by its representatives in the House of Delegates of the American Medical Association, is on record as being opposed to any extension of such service in the non-service connected case, and advocates in lieu thereof, an insurance benefit providing a hospital, and weekly cash, indemnity for the totally disabled. Under such a plan some of the fundamental principles of medical practice are preserved. The patient will be left to choose his own hospital and his own physician, will pay them on a fee basis, and thus be independent and not an object of charity.

According to the figures of Dr. Shoulders, the originator of the plan, besides eliminating building costs, the government would save hundreds of thousands annually and at the same time would not interfere with the operation of the civilian hospital. Under the plan equal benefits would be afforded to all veterans. This is not possible under the present system. The insurance system would be much more just to physicians of the country, especially those who were themselvs in the service. More particularly, it would prevent the initiation of a system of state medicine, in its most vicious form, which would undoubtedly be extended to other classes than veterans in the years to come.

We therefore recommend either the Shoulders' plan or some similar program as endorsed by the American Medical Association, for the benefit of disabled veterans.

7. This Committee does not presently suggest any change in the Medical Practice Act but when change is to be made in the legislature, authority is requested that the following procedures may be included:

a. To repeal the provision permitting itinerant practice for a fee of $250.

b. To provide for injunctions against the unlicensed practicing medicine pending trial.

c. To provide that those licensed in the state must produce their license in court upon request.

d. To provide that the present law requiring first citizenship papers as a prerequisite to licensure be changed to provide for a full citizenship.

e. To provide that medical students would be permitted to take their examinations at the end of their school year but that license shall be withheld until receipt of certificate from the school dean that internship has been completed.

f. To repeal that portion of the law which provides that no instructor, stockholder, member of or person financially interested in any school, college or University having a medical department shall not be eligible for appointment to the Board.

8. Permission is requested to reintroduce measures to provide that a physician shall be a member of all county and city health committees.

9. Permission is requested to support legislation to be introduced by the Wisconsin Pharmaceutical Society to curb the counter dispensing of habit-forming drugs (hypnotic) which do not now come under the State Medical Law.

Unless this House directs to the contrary, this Committee will undertake a study of the model law governing the Board of Health of New York State. It will also ask of the Commissioner of Insurance of Wisconsin that he use his best efforts in the public interest to the end that insurance companies (life or health) who offer insurance without medical examinations shall be required to bear the burden of proof that the applicant knew of his illness at the time of making his application in event that it is later discovered that the applicant was in fact ill at the time his application was accepted.

This Committee has made a careful study of several other important questions bearing upon the public health and will present supplementary reports to the House or Council as the year progresses.

Respectfully submitted,

Otho A. Fiedler, M. D., *Chairman*,
Reginald Jackson, M. D.,
S. M. B. Smith, M. D.,
J. G. Crownhart, *Secretary*.

REPORT OF THE EDITORIAL BOARD

To the 1932 House of Delegates:

One year ago your Editorial Board initiated the plan of employing a physician on part-time basis to assume to a large extent the duties that had heretofore been carried by the members of the Board. After some consideration Dr. John Huston of Milwaukee was appointed Medical Editor of the JOURNAL. I believe the Board was particularly fortunate in obtaining the services of Dr. Huston, as he was not only willing to accept the position under the very small remuneration offered, but has taken over his duties with a pleasure and enthusiasm that promises well for our publication. The experiment—if one may call it such—is still in its infancy, but up to the present time has worked out very successfully.

That our JOURNAL would some time have the benefits and advantages of a full-time Medical Editor has been in the minds of the members of your Board for many years, and that the present small beginning may eventually grow into a realization of these dreams is the sincere desire of your Board. We hope that State Society will see fit to continue the present policy. The JOURNAL of the state Society is after all but an expression of the profession of the State and as such it should be truly representative of the best.

Questions of policy of the JOURNAL and articles of a debatable nature have invariably been referred to the Board for decision.

The cancellation of many advertising contracts during the past year has been a serious blow to the Managing Editor, but with the readjustments made by cutting down the size of the JOURNAL, it is hoped that the deficit will be materially decreased.

To both Dr. Huston and Mr. Crownhart much credit is due for the high standards maintained by your JOURNAL during the past year.

Respectfully submitted,

OSCAR LOTZ,

Chairman of the Editorial Board.

REPORT OF THE COMMITTEE ON HEALTH AND PUBLIC INSTRUCTION

To the 1932 House of Delegates:

Carrying on the long established policies repeatedly approved by your House, this Committee has centered its attention on three principal forms of lay educational effort:

1. Hygeia.

Under the auspices of the Society, 250 subscriptions to Hygeia, each accompanied by a personal letter to the recipient from the Secretary were presented at Christmas time. The recipients included all members of the legislature, state officers including members of the Industrial Commission, Justices of the Supreme Court, and others having to do with questions involving health and the medical profession, libraries of the seven teachers colleges, the circuit judges and district attorneys, interested newspaper editors and a selected group of laymen who have long evidenced their interest in public health advance.

This Committee annually receives large numbers of acknowledgments and is convinced that this service is worthy of continuation.

We are pleased to report action of the State Superintendent of Schools has resulted in Hygeia being placed on the approval list for school subscriptions to which the state contributes.

2. Radio Broadcasts.

As cited in the Report of the Secretary, the Society is now broadcasting twice weekly over Station WHA of the University of Wisconsin, and this material is advanced to health officers for rebroadcast over the state station at Stevens Point and the station at Sheboygan. One broadcast each week is of five minutes duration while the other is a ten minute period.

These broadcasts are prepared in the office of our State Society and delivered by Miss Buellesbach, assistant secretary. We anticipate that during the coming months additional Wisconsin stations will be using this central service and it is of interest to the Committee to know that these broadcasts have brought forth a very considerable amount of correspondence from an interested listening group covering a large territory in the state.

The titles of the broadcasts from Sept. 1st to July 1st are listed herewith as indicating the scope of this excellent effort:

(5 minute talks)

Ulcers of the Stomach.
The Young Sick Child at Home.
Diseases of the Human Breast.
Teeth of the School Children.
Headache.
Growing Pains or Rheumatism?
Children's Colds.
Bright's Disease.
Walk for Your Health.
Scarlet Fever.
Whooping Cough.
Tularemia.
Gaining the Child's Confidence.
How Diseases are Spread.
How Parents Can Help to Prevent the Spread of Contagion.
Serve Yourself Sufficient Sleep.
Christmas Shopping.
Concerning Germs.
What to do When a Bone is Broken.
Preventive Inoculation.
Teach the Child to Like Wholesome Foods.
The Turn of the Century.
Electrical Hazards in the Home.
Electrical Hazards Outside of the Home.
Prevention of Tuberculosis.
Measles.
Food and Health.
Anemia in the Young Girl.
Worry Warps the World.

Your Weight.
Depression a la Carte.
The Story Your Hands Tell.
Children's Parties.
How Do Your Children "Rate" you?
What Do You Know About That?
Stretching the Food Dollar.
Gas—Friend or Enemy?
The Fight Against Tuberculosis.
Your Heart.
The Most Nearly Perfect Food.
Accidental Poisoning.
The Hospital.

(10 minute talks)

The Health Market.
Convulsions in Infancy and Childhood.
Microbes and Man.
The Menace of Malnutrition.
Some "Highspots" in Fifty Years of Medical Progress.
Blood Transfusions.
Little Glands with Big Jobs.
Health Factors.
The Organ of Hearing.
Avoid that Cold.
Tuberculosis.
Mental Hygiene in Home and School.
The Nature of Cancer.
Sinus Disease.
Carbon Monoxide Monster.
A Pioneer Heroine—Mrs. Jane Todd Crawford.
The Problem of Sweets for Children.
Dangers of "Light Treatment."
Speed and Leisure.
Those Troublesome Teens.
Laennec the Listener.
Hygeiene of the Heart.
Pneumonia as a Preventable Disease.
Sport for Health's Sake.
Whooping Cough.
Diabetes
Anemia.
Wisconsin Babies.
This Matter of Reducing.
Do Your Feet Hurt?
Longevity.
The Old Medicine Chest.
The Defeat of Diphtheria.
Climate and Tuberculosis.
Food for Children from Two to Six.
Accidental Poisoning.
A Tooth Brush for the Baby.
Those Glasses We Wear.
Keeping the Baby Well.
Vacation Hazards.
Safety First in the Water.
Diseases of the Skin.
Food Faddists.
Mad Dog.

3. Press Service.

Again continuing this well established lay educational project, the press service of this Society has issued forty-four weekly releases during the nine months since the last annual meeting. These releases are used regularly by a large proportion of the weekly and daily papers of the state and from time to time by almost all of the rest of the press. We are convinced of the worthiness of this effort. It carries to thousands upon thousands of readers articles from authoritative sources advising the public of that which should be common knowledge in the field of the prevention and relief of disease by scientific medicine. For the information of the members, we have printed these releases in each issue of our Medical Journal. Here indeed is an instance of a joint service to public and profession that is worthy of every dollar of the appropriation made available for this purpose. That members may be familiar with the scope of the work we are again listing the titles of the articles released during the past nine months.

Cancer of the Skin.
The Children's Meals.
Diseases of the Heart.
Pimples.
Athletics.
High School Athletics.
The Week End Vacation.
Mental Depression.
Sinus Trouble.
The No-Breakfast Fad.
Dropsy.
Regularity in Meals.
Communicable Diseases.
Measles.
Behavior of Children.
Pneumonia.
Christmas Gifts.
Automobile Accidents.
Accidents in the Home.
Sunbaths for Babies.
Overweight.
Home Ventilation.
Mental Illness.
"Just a Cold."
Accidents and Tuberculosis.
Croup.
Cancer Among Women.
Paralysis.
Pneumonia.
Cancer.
Disease Carriers.
Cooking Pork.
Cod Liver Oil.
Infected Teeth.
Pyorrhea.
Cancer.
Crooked Teeth.
Insulin and Diabetes.
Insulin and Diabetes.

Insulin and Diabetes.
Measles.
Broken Bones.
Birthmarks.
Pure Drinking Water.

This Committee urges upon the House continuance of these established services.

Respectfully submitted,
W. D. Stovall, M. D., Madison, *Chairman.*
H. M. Stang, M. D., Eau Claire.
C. M. Gleason, M. D., Manitowoc.
J. G. Crownhart, *Secretary.*

REPORT OF THE COMMITTEE ON MEDICAL DEFENSE

To the 1932 House of Delegates:

As in the past, there have been brought to the attention of your Committee a number of cases in which defense was requested. These cases varied in character, the largest number pertaining to alleged improper treatment of fractures.

Because of the fact that the original procedures and regulations of the Committee have become out of date, your Committee met in Madison for an entire Sunday to pass upon a revision of both rules and procedures. This revision is rapidly nearing completion and will be published for the information of all members. A tremendous amount of research work into the rules existing under other state plans was essential as a preliminary to our conference and the Committee is pleased to report that the newer procedures are drafted to afford the broadest possible type of defense to the deserving member but maintaining for the Committee the right to review all cases. We are confident that the improved plan will give an even greater appeal to the general membership.

There is attached to this report letter from legal counsel of the Committee outlining in part his services for the Committee since his employment in 1930. One needs but read this to be impressed with the service that is rendered. It is of course regrettable that a considerable proportion of the Society membership remains without this Society protection. We are self-supporting and do not ask for larger support for income sake. In an altruistic sense only, knowing that we can be a real force behind the unfortunate members, are we appealing for more members to avail themselves of the benefits the State Society Medical Defense offers.

RECOMMENDATION

Under the present by-laws of the Society a member is not entitled to medical defense if his dues are not paid by February 1st of each year. Inasmuch as the Society itself does not remove a member from the mailing list or consider him in arrears for all other purposes until March 31st, it is our recommendation that the by-laws be amended to grant a like time extension for Medical Defense. The proposed amendment follows:

Amend Section 3, Chapter VIII, By-Laws of the State Medical Society of Wisconsin by striking out the words "February 1st" where they occur therein and substitute therefore the words "March 31st".

Respectfully submitted,
Arthur J. Patek, *Chairman.*
Arthur Sullivan,
W. C. Becker.

ADDENDA

Milwaukee, July 7, 1932.

Dr. Arthur J. Patek,
425 East Wisconsin Avenue,
Milwaukee, Wisconsin.
My dear Doctor Patek:

I have for acknowledgment your letter of July 5, 1932, and gladly comply with your request. My professional services for the Association began in the summer of 1930. Since then payments have been made to me as follows:

In October, 1930	$135.00
In January, 1931	165.00
In April, 1931	213.00
In January, 1932	302.54
In April, 1932	415.00
Total	$1,230.54

ANALYSIS

1930

Dr. A. Alleged negligence; fracture case; improper reduction and failure to use x-ray. Bill for $135.00 rendered and paid. Further payments were made in this case of $165.00 in January, 1931, and $150.00 in April, 1931. This payment of $150.00 was embraced in your check of $213.00 received by me in April, 1931. The balance of $63.00 covered six other matters where the payments involved ranged from $3.00 to $15.00; services consisting in conferences, offers of assistance, reviewing files, etc.

1931

Dr. B. Alleged negligence; fracture case; improper reduction. Bill for $42.00 was rendered and paid. A further bill for $25.00 was rendered in April, 1932, and likewise paid.

Dr. C. Alleged negligence; fracture case; improper reduction. Case handled by insurance carrier. Charge of $10.00 was made for conferences. A further bill for $20.00 was rendered in April, 1932, and the same has been paid.

Dr. D. Alleged negligence uncertain. Summons alone served. Charge of $15.00 for conferences. Bill rendered and paid.

Dr. E. Alleged negligence; improper diagnosis. Bill for $165.00 was rendered in December, 1931, and the same has been paid. In addition, disbursements amounting to $30.54 have been paid. A further bill for $45.00 was rendered in April, 1932, and the same has been paid.

Dr. F. Alleged negligence; fracture case; improper reduction. Suit has not been commenced. Charges are for conferences and statement. Bill for $15.00 has been rendered and paid.

1932

Dr. G. Alleged negligence; sponge case. Bill for $55.00 has been rendered and paid.

Dr. H. Charges in this matter are for conferences. No action has been started. Bill for $25.00 has been rendered and paid.

Dr. I. Alleged negligence; improper diagnosis. Bill for $25.00 was rendered and paid. Further bill for $175.00 was rendered in April, 1932, and the same has been paid.

Dr. J. Alleged negligence; improper diagnosis. Bill for $65.00 has been rendered and paid.

If I can be of further service, kindly advise.

I return herewith statement in accordance with your request.

Very truly yours,
ROBERT R. FREEMAN.

REPORT OF THE MEDICAL EXTENSION COMMITTEE

To the 1932 House of Delegates:

Three postgraduate medical extension courses were projects of the State Medical Society and co-operating organizations during the year which closed on June 30, 1932. The number was slightly under the previous year's, and the enrollment also was smaller, all of which reflects the general economic trend. On the whole, however, the courses were successful, and proved to be an economical and worthy alternative for a postgraduate course in a medical school.

In this program the University of Wisconsin Medical School actively co-operated, and the University Extension Division again undertook the task of organizing the classes, selecting places of meeting, and assisting the visiting lecturers.

This was the fifth year of what was originally intended to be an eight-year program of medical extension work by the three agencies above mentioned. Whether the program shall be continued will probably depend upon the betterment of economic conditions. With the pressure for financial retrenchment a compelling force upon all state-supported institutions, continuance of the work is problematical, at least until there is assurance that the costs will be covered by the enrollments. At the present time a decision on this question must await economic improvement.

THE PAST YEAR'S PROGRAM

The year's instruction program included two courses in Obstetrics and Gynecology, one begun in the last month of the previous year and the second in June, 1932; and a course in Otology, held in May, 1932.

The first course in Obstetrics was held for twelve weekly meetings in six cities, from June 15 to September 4, 1931. The instructors were Dr. Everett D. Plass, of the University of Iowa Medical School, and Dr. Otto H. Schwarz, of the Washington University Medical School, St. Louis. The enrollment was as follows: Appleton, 15; Green Bay, 27; Marinette, 13; Sheboygan, 20; Oshkosh, 21; Manitowoc, 19; total, 115.

The course in Otology was held at the Wisconsin General Hospital in Madison on May 9–13, 1932, under Dr. Erich Ruttin, chief of the Department of Otology at Rudolf Spital in Vienna, an internationally known teacher of the subject. It is believed that no more skilled teacher of Otology could have been obtained for our Wisconsin course.

The second course in Obstetrics and Gynecology, which is now in progress was begun on June 13 and will continue until September in the following southwestern centers: Tomah, La Crosse, Richland Center, Platteville, and Monroe. The instructors are Doctors Plass and Schwarz, who served the Fox River valley circuit in the same capacity last year. The enrollment at this writing is incomplete.

A course in Pediatrics also was organized in the spring of 1932, to be given for six weeks during the summer, beginning July 11, at Milwaukee (2 classes), Waukesha, Racine, Kenosha, and Burlington. The instructor will be Dr. Wayne A. Rupe, of Washington University, St. Louis, who four years ago conducted a similar course in other Wisconsin cities.

MEDICAL LIBRARY TRANSFERRED

The Medical Library, giving package library service to Wisconsin physicians on medical topics, which has been supported by an appropriation of $5,500 to the Extension Division, was this year transferred to the Medical School. This action was taken as a result of the executive veto of the appropriation in the interest of retrenchment during the 1931 session of the Legislature. Practically all of the $5,500 fund had been used for the package library service for physicians. With its discontinuance by the Extension Division, Dean C. R. Bardeen was able to obtain a special fund of $500 with which to employ a worker to continue the service in a limited manner. It is certain that every effort will be put forth by the Medical School to continue the work without sacrificing its efficiency in any material degree.

Respectfully,
CHESTER D. SNELL,
Dean, University Extension Division,
For the Committee.

COMMITTEE ON NECROLOGY

To the 1932 House of Delegates:

The Council, as the Committee on Necrology, has the sad duty of reporting the deaths of the following physicians since the last Annual Meeting (members of the Society are indicated by bold face type):

Anderson, Harold B. ---------- Beloit
Armbruster, B. F. ---------- Milwaukee
Benson, Albert M. ---------- Hartford

Boorse, Lorenzo ..... Milwaukee
Brett, Benjamin C. ..... Green Bay
Brewer, J. B. ..... Jefferson
Brown, Robert C. ..... Milwaukee
Buck, Guerdon C. ..... Platteville
Chandler, Fremont E. ..... Waupaca
Christensen, Emil ..... Two Rivers
Christiansen, George ..... Galesville
Clark, J. H. ..... Unity
Cutler, John W. ..... Milwaukee
Doege, Karl W. ..... Marshfield
Dreyer, Richard A. ..... Wheeler
Evans, Edward ..... La Crosse
Fawcett, W. E. ..... Bayfield
Felter, Edward B. ..... Plymouth
Foster, Argo M. ..... Racine
Fox, Philip ..... Madison
Fucik, Edward J. ..... Williams Bay
Fulton, H. A. ..... Eau Claire
Goddard, J. B. ..... Eau Claire
Griswold, F. L. ..... Mazomanie
Hall, Sidney Storrs ..... Minneapolis, Minn.
Hayward, J. C. ..... Marshfield
Hicks, Levi N. ..... Burlington
Higgins, Edward G. ..... Melrose
Hugh, William H. ..... Kenosha
Hutchins, S. E. ..... Trempealeau
Johnston, H. E. ..... Oshkosh
Kaumheimer, Gustav J. ..... Milwaukee
Kemper, W. G. ..... Manitowoc
King, Charles F. ..... Hudson
Lindores, J. D. ..... Stevens Point
Maurer, H. C. ..... Beloit
Mertens, H. G. ..... Bayfield
Minshall, Albert P. ..... Viroqua
Mitchell, F. W. ..... Medford
Moore, W. N. ..... Appleton
Nolan, W. N. ..... Kaukauna
Ogden, Henry V. ..... Milwaukee
Pattee, George W. ..... Janesville
Perrin, G. H. ..... Menomonee Falls
Porter, C. V. ..... Viroqua
Reineck, Charles ..... Appleton
Robbins, G. H. ..... Madison
Robey, Marion L. ..... Edgar
Rood, Myron G. ..... Stevens Point
Ross, John M. ..... Richland Center
Salbreiter, W. P. ..... Racine
Sarles, W. T. ..... Sparta
Schapiro, Louis ..... Milwaukee
Stack, Stephen S., Sr. ..... Milwaukee
Steele, G. M. ..... Oshkosh
Taugher, Patrick J. ..... St. Nazianz
Turner, James F. ..... Waupun
Wyatt, John McK. ..... Madison

Respectfully submitted,

The Council

J. G. Crownhart, *Secretary.*

REPORT OF THE CANCER COMMITTEE

To the House of Delegates:

The plans of this committee, which have been maturing during the last two and a half years, are now beginning to materialize. Previous reports to the House have outlined in detail the activity planned.

The report of the survey conducted by the American Society for the Control of Cancer has been accepted by the Council and will be published soon in one issue of the Journal. This report brings out some very important facts concerning the facilities in the State for the diagnosis and treatment of cancer. It also shows how cancer has increased in this State during the last two decades.

Cancer has become a public problem in almost every country in the world. Many European countries have recognized the importance of cancer control and the governments have taken over the diagnosis and treatment of these cases in centralized, government controlled hospitals. The necessity for this governmental activity has resulted from the inadequacy of private institutions to finance the purchase of the expensive equipment needed or to secure a staff with sufficient training and skill to properly carry out the procedures involved in modern methods of diagnosing and treating cancer. Your committee, knowing these facts, thought it important to get the facts about the situation in Wisconsin.

There are in the State one hundred and seventeen (117) hospitals receiving so-called private or pay cases. It was obviously impossible and indeed unnecessary to investigate each one of these hospitals as to its method of handling cancer cases. The report is based upon a survey of forty-nine (49) of the larger hospitals located in the large centers of population.

After studying this report, your committee made some definite recommendations to the Council; briefly these recommendations revolved around the apparent necessity of stimulating an interest within the profession in the control of cancer and the necessity for the profession to make some organized efforts to satisfy some of the deficiencies which now exist.

This point is illustrated in the facilities now existing for the microscopic study of tissue, fresh frozen at the time of operation and later paraffin sections. The report indicates that out of the forty-nine (49) hospitals included in the survey there were eight (8) without any laboratory equipment for the study of tissues and six (6) with the apparatus but without the services of a pathologist and in a majority of the hospitals the laboratory is run by a technician. The number of hospitals either without laboratory equipment (8) or without a pathologist (6) is thirty percent (30%) of the hospitals included in the survey. When one recognizes that these forty-nine (49) hospitals represent the largest and best in the State and that thirty percent (30%) are without pathologists, the importance of the job undertaken is immediately obvious.

The Council, therefore, at the January meeting accepted the recommendation that a permanent cancer committee be appointed, one from each Councilor District, and instructed the President, Doctor Fiedler, to appoint the committee and to instruct the

committee to report back to the Council its suggestions concerning the rest of the proposals growing out of the survey. The permanent committee appointed by Doctor Fiedler was made up of the following members:

Dr. H. M. Stang, Eau Claire
Dr. Herman Wolf, La Crosse
Dr. F. W. Pope, Racine
Dr. F. Eigenberger, Sheboygan
Dr. F. Gregory Connell, Oshkosh
Dr. W. E. Ground, Superior
Dr. Paul Doege, Marshfield
Dr. S. J. Seeger, Milwaukee
Dr. G. R. Duer, Marinette
Dr. J. F. Wilkinson, Oconomowoc
Dr. E. H. Spiegelberg, Boscobel
Dr. W. D. Stovall, Madison, (Chairman).

The recommendations for the consideration of this committee can probably be better comprehended by the introduction of the report to the Council by the old committee.

"1. The establishment of a permanent Cancer Committee for the State Society, a majority of the membership never changing in one year. It is suggested that this Committee be composed of at least one member from each councilor district and, when feasible, that the chairman be the State Chairman for the American Association for the Control of Cancer.

"2. The organization of a lay auxiliary committee to work with the State Society Committee.

"3. Provide for permanent Cancer Committees for each of the component County Societies, a majority of whose membership shall not expire in any one year.

"4. Authorize the development of a record system for hospitals receiving cancer patients.

"5. Provide for a central tumor registry where tumors removed in various hospitals can be sent for record and filing. These tumors must be accompanied by clinical histories, descriptions of operations, findings at operation and other pertinent matter which the Committee may deem necessary. In order for a hospital to join the tumor registery it will be necessary to provide itself with a record system worked out by the Committee and to be able to supplement this record by a yearly follow-up on each case. The follow-up must be the designated duty of some hospital employee and will be carried out by mailing to these patients or their relative a form letter requesting the information desired.

"6. Authorize a meeting at least twice a year of the interested staff members of the hospital belonging to the tumor registry, the meeting to be called by the Chairman of the Cancer Committee.

"7. Provide that the records and tissues on file in the registry be open at all times to members of the profession who wish to use them for study.

"8. Discuss with the State Board of Health the advisability of making cancer a reportable disease.

"9. Initiate a professional and lay educational program through the cooperation of the agencies and along the lines suggested in the report of the American Society for the Control of Cancer.

"10. Authorize the publication of the report in one issue of the State Medical Journal.

"11. Authorize the drafting of a set of resolutions expressing the thanks and appreciation of the Council to the American Association for the Control of Cancer and Dr. Rector for the survey."

The new committee recommended to the Council the adoption of this report. The Council accepted this recommendation at its April meeting.

The present cancer committee is therefore made up as above described and is busy at the present time with plans to put into operation the recommendations contained in the report.

In addition your committee working with the program committee succeeded in securing a prominent place on the program for cancer at the State meeting last year and also with the cooperation of the dentists and Woman's Club secured large audiences for Doctor Bloodgood, who spoke on The Control of Cancer to the Woman's Club and held a clinic on The Diagnosis of Tumors of the Jaw for the dentists. We also secured the Canti film and had it running during the forenoon and afternoon on each day of the meeting. This year the program committee has also allowed us a generous place on the program.

Respectfully,
W. D. Stovall, *Chairman,*
For the Cancer Committee.

REPORT OF COMMITTEE ON MEDICAL EDUCATION AND HOSPITALS

To the 1932 House of Delegates:

In the June issue of the Wisconsin Medical Journal there is an interesting summary of statistical data relating to Wisconsin hospitals, showing average bed occupancy, average cost per bed and average indebtedness in hospitals of various bed capacity. For hospitals with less than 50 beds the cost per bed was $2331 and there in an indebtedness of 40%, for hospitals of 50–100 beds the average cost per bed was $2827 and the average indebtedness is 55%, for hospitals with over 100 beds the average cost was $3374 per bed and the average indebtedness 49%. This indebtedness is a severe handicap in these times of depression. Under ideal conditions public hospitals under private control should be free from debt and be well endowed. First class hospital care is necessarily expensive, largely owing to the expert personal service it involves. It is in the public interest to have such service placed within the reach of all who really need it. Indebtedness to be paid off increases cost of care. At present there appears to be more need of freeing hospitals from indebtedness than in establishing new hospitals in most parts of the state.

In medical education there have been no striking changes during the past year. The new building at Marquette is a great addition to its resources.

Respectfully submitted,
C. R. Bardeen,
For the Committee.

The Nurse in Industry*

By J. G. CROWNHART, Secretary
State Medical Society of Wisconsin
Madison

The Workmen's Compensation Act of Wisconsin is one of the greatest pieces of humane legislation ever enacted in this state. Its motive is to provide a degree of economic security for the man who has been maimed in industry. But even more important, its development since 1911 has constantly stressed accident prevention and a high type of service for the injured that their disability may be lessened and their non-productive period reduced insofar as medical and surgical science is able to accomplish that joint aim. On this latter point the law itself declares that "the employer shall supply such medical, surgical and hospital treatment, medicines, medical and surgical supplies * * * as may be reasonably required * * * immediately following the injury to cure and relieve from the effects of the injury * * *". In 1915, speaking before the State Medical Society of Wisconsin, my father, then retiring chairman of the first commission declared on this point "As these humane steps are taken, the doctors of medicine will become more and more the agency of administration of the system" and "no body of men has greater interest in the matter than the physicians—no body of men can do more to make the law a success."

Here we have definitely and concisely the viewpoint of the lawmaker and the administrator. From the viewpoint of the employer and his insurance carrier, the matter of costs is essential if the employer is to obtain insurance to advantage and manufacture a product that can compete in price with those manufactured elsewhere. These viewpoints are not divergent ones. In the field of the nurse in industry, however, a divergence has crept in which your State Medical Society has endeavored, as best it might, to eliminate in the interest of affording proper relief to the injured workman.

An insurance representative, addressing himself to the question of the nurse in industry, declared that "the first idea of the insurance carriers * * * in promoting industrial nursing was to effect a reduction in the cost of the industrial accidents primarily to reducing the costs of medical services rendered by physicians".

Physicians were quick to sense this growing change and from many parts of the state reports came to the offices of your Society that in some instances they were seeing cases too late to render the most efficient treatment; that frequently the workman had incurred a greater disability through the inadequate services proffered the employee as competent.

This entire matter came to a head in the legislature of 1931 when after an opinion of the State Society that the nurse in industry was not yet licensed to practice medicine, a bill was heard which provided in part to permit the "industrial nurse" to administer first aid, apply dressings, prescribe family remedies and medicines allowed by law to be sold without a prescription for injured or sick employees or to their immediate families. Here indeed was the economy position of the insurance carrier brought to absurdity.

When the committee hearing was called on this measure the nurses in industry themselves were present to oppose the bill and the hearing had not progressed beyond the first speaker before permission was asked to withdraw the measure. The representative of one of the largest insurance carriers in Wisconsin then suggested to your Secretary that in the joint interest of the employer and employee, your State Society could afford a great public service if it would promote a suggested set of standing orders that might be signed by the plant physician for the nurse in industry. Your Society was prompt to accept the suggestion and in 1931 President Harper appointed as such a committee Drs. A. W. Gray, Milwaukee, Chairman; Wilbur LeCron, Edward Quick and C. S. Beebe of Milwaukee; C. F. N. Schram of Beloit and Arthur Sullivan of Madison with the State Secretary acting as Secretary of the

(Continued on page 578)

* Reprinted from The Milwaukee Medical Times, Medical Society of Milwaukee County, July, 1932.

PRESS SERVICE OF STATE MEDICAL SOCIETY

No serum does so much for public health as printer's ink

PURE WATER

Madison, Wis., June 30.—Summer camps in Wisconsin are guaranteed a purer water supply this year as a result of stringent regulations taken by the State Board of Health to insure pure drinking water for all tourists entering Wisconsin. Samples of water at all places where tourists visit have recently been tested by the State Board of Health and wells condemned have been closed.

Wisconsin has been making a fight to reduce the typhoid rate. Insuring a pure water supply has been the avenue of attack. The Educational Commlttee of the State Medical Society in a bulletin on water supplies today declares that the great drop in typhoid fever rates has been due to the state's policy in protecting the water supply.

"Carelessness in selecting drinking water by vacationists is the cause of many cases of typhoid fever," declares the Health Committee bulletin. "Cities are able to protect their citizens against typhoid fever to a large extent by vigilance in maintaining and furnishing a pure water supply. These cities find themselves helpless to prevent the sporadic case of typhoid which is contracted during vacation.

"Before suitable purification and control methods were instituted many cities had the reputation of supplying water which was not always satisfactory. Since purification and control have been installed practically all cities furnish very pure water. These supplies can be and should be relied upon to yield a water which is pure and wholesome. Do not think because a water has been purified that it is not good to use; quite the contrary, consider that the city has done the purification which is ordinarily left to be done by natural processes, and which is not always complete or satisfactory.

"All Wisconsin municipal water supplies are inspected periodically by a sanitary engineer of the State Board of Health. The purity of the water is controlled by frequent examinations done at the State Laboratory of Hygiene. Municipal supplies are safest.

"Consider all surface waters as unfit for use because they usually are. Drink no water from the 'crystal brook' because it may be badly polluted farther up stream by drainage from barns, privies and cesspools. Lakes must also be considered unsafe as a supply. The numerous camps and cottages on the banks of Wisconsin lakes serve as a warning of pollution to the motorist.

"Many, though not all local rural supplies are safe sources of water for the campers. A casual inspection of the well, curb and surroundings may help serve as a guide to the users of the character of the water. Roadside springs frequently are unsafe because of the source of the spring water.

"Boiling of a polluted water for five minutes is a simple method for the purification of small quantities of water for drinking. Carry a tank of pure city water on your car for emergency use the same as you do your tent. It may become warm but not likely polluted. Use iced water rather than ice in the water as a pure water may be rendered impure by putting polluted ice into the water to be drunk. Think before you drink!"

* * *

KEEPING THE BABY COMFORTABLE

Madison, Wis., July 7.—The cry of a baby on a summer night may be no indication of hunger, but may be the result of overfeeding.

"During the summer months it may be advisable to reduce the amount of food given," declares the bulletin of the State Medical Society issued today.

"Even older children who are on a more or less mixed diet should be guarded from the dangers of overfeedlng in hot weather," continues the bulletin. "Be sure that all food is perfectly fresh and is protected from dust and flies. Wide-open doors and windows which add so much to the joy and wholesomeness of living may at the same time, unless carefully screened, bring a danger into our dwellings. The fly and mosquito should receive no quarter from the mothers of little children. They may be carriers of dangerous diseases.

"Though it is advisable to reduce the amount of food given in hot weather, the amount of water usually should be increased. Give the infant and little child plenty of cool, boiled water. The increased loss of water from the body through perspiration naturally produces thirst, and neither child nor adult can be comfortable when he is thirsty. Usually a child will ask for water when he is old enough to talk, but the little one who has not yet found his tongue needs the water he cannot ask for.

"Suitable clothing, right living habits, and a wholesome environment are essential to the child's well being. In the matter of clothing, be guided by temperature rather than by tradition or fashion. Do not bundle up the baby with many layers of heavy clothing when the mercury is climbing high in the thermometer. The lightly clothed little child in hot weather, whether infant or runabout, is becoming the rule rather than the exception.

"No matter in what season of the year the baby is born, healthy living habits should be started in the very beginning of its life. The little one who has to face a temperature of ninety degrees with no fixed and established regularity in habits of feeding, bathing, sleeping, and airing, is under a serious handicap. If the baby is being fed every four hours, the interval should not be shortened to three or lengthened to five simply to suit someone's convenience. The older child on a regular three-meals-a-day schedule should not have its appetite spoiled and its digestion probably upset by 'piecing' between meals from the soda fountain, the pastry shop, or the confectioner's.

"The daily bath, to which the child has been accustomed since birth, probably will have to be supplemented by extra spongings during the hot summer. Few things are more refreshing and helpful on a hot, muggy day than a sponge bath.

"Plenty of rest and sleep are essential always, and never more so than in summer. The nap, in a cool darkened room or quiet porch, and early bedtime are wonderful conservers of the little one's strength. Every mother should cling to the nap or rest periods until the baby is well past infancy."

* * *

FRUIT AND HEALTH

Madison, Wis., July 14—Summer is the best time to reduce in weight. It is easier to diet and there are more foods and vegetables on the market which have a tendency to keep the weight down.

Children should not be allowed to reduce during the summer months, however. They play so extensively that there is little danger of their weighing too much, according to the bulletin of the State Medical Society of Wisconsin issued today. The bulletin declares that there is little danger of any person under thirty years

(Continued on page 576)

THE JOURNAL BOOK SHELF

Biochemistry in Internal Medicine. By Max Trumper, PH. D., clinical chemist and toxicologist; formerly in charge of the Laboratories of Biochemistry of the Jefferson Medical College and Hospital and of the Psycho-Biochemistry Laboratory, Graduate School of Medicine, University of Pennsylvania; and Abraham Cantarow, M. D., instructor in medicine, Jefferson Medical College; assistant attending physician, Philadelphia General Hospital; in charge of Laboratory of Biochemistry, Jefferson Hospital. 454 pages with illustrations. Philadelphia and London: W. B. Saunders Company, 1932. Cloth, $5.50 net.

Lang's German-English Dictionary. Revised and edited by Milton K. Meyers, M. D., neurologist to the Northern Liberties Hospital; chief of Nerve Clinic, St. Agnes Hospital; consulting neurologist, Jewish Hospital, Philadelphia. Fourth edition enlarged. Price $10.00. P. Blakiston's Son & Co., Inc., 1012 Walnut Street, Philadelphia, Pennsylvania.

The Healing Cults. A study of sectarian medical practice: its extent, causes and control. By Louis S. Reed, Ph. D. Price $2.00. University of Chicago Press, Chicago, Illinois.

Pathology for Nurses. By Eugene C. Piette, M. D., pathologist and director of the Clinical Laboratories of the West Suburban Hospital, Oak Park, Illinois: Consultant Pathologist, Chicago State Hospital. With 65 illustrations, some in color. Price $1.75. F. A. Davis Company, 1914 Cherry St., Philadelphia, Pa.

Obstetric Education. Report of the subcommittee on obstetric teaching and education, Fred Lyman Adair, M. D., Chairman. White House Conference on Child Health and Protection. Price $3.00. The Century Co., New York.

Growth and Development of the Child. Part III. Nutrition. Report of the Committee on Growth and Development. Kenneth D. Blackfan, M. D., Chairman. White House Conference on Child Health and Protection, The Century Co., New York. Price $4.00.

Surgical Errors and Safeguards. By Max Thorek, M. D., surgeon-in-chief, The American Hospital, Chicago; attending surgeon, Cook County Hospital; corresponding member, Societe Des Chirurgiens De Paris, France; associate Royal Academy of Medicine, Torino, Italy. 668 illustrations. J. B. Lippincott, Company, Philadelphia, Price $10.00.

BOOKS RECEIVED FOR REVIEW

Manual of Clinical and Laboratory Technic. By Hiram B. Weiss, A. B., M. D., associate professor of medicine, College of Medicine, University of Cincinnati; and Raphael Isaacs, A. M., M. D., associate professor of medicine, assistant director of the Thomas Henry Simpson Memorial Institute for Medical Research, University of Michigan. Fourth edition, reset. 117 pages with diet table. Price $1.50 net. W. B. Saunders Company, Philadelphia.

A Manual of Pharmacology. By Torald Sollmann, M. D., professor of pharmacology and materia medica in the School of Medicine of Western Reserve University, Cleveland, Ohio. Fourth edition, thoroughly revised. Octavo of 1237 pages. W. B. Saunders Company, Philadelphia. 1932. Price $7.50 net.

Minor Surgery of the Urinary Tract. By Herman C. Bumpus, Jr., Ph.B., M. D., in urology, F. A. C. S. section on urology, the Mayo Foundation. Octavo of 124 pages with 57 illustrations. Price $3.00 net. W. B. Saunders Company, Philadelphia. 1932.

Materia Medica, Pharmacology and Therapeutics. By Walter A. Bastedo, Ph.G., M. D., assistant clinical professor of medicine, Columbia University; consulting physician, St. Luke's Hospital, New York, St. Vincent's Hospital, Staten Island and the Staten Island Hospital; President, United States Pharmacoloeial Convention, 1930–40. Price $6.50 net. Third edition. W. B. Saunders Company, Philadelphia, 1932.

Electrosurgery. By Howard A. Kelly, M. D., Baltimore, Md., and Grant E. Ward, M. D., Baltimore. 305 pages with 382 illustrations by William P. Didusch and others. Price $7.00 net. W. B. Saunders Company, Philadelphia, 1932.

1931 Collected Papers of the Mayo Clinic. Volume XXIII. Edited by Mrs. Maud H. Mellish-Wilson and Richard M. Hewitt, B. A., M. A., M. D. Octavo volume of 1231 pages with 265 illustrations. Price $13.00 net. W. B. Saunders Company, Philadelphia, 1932.

BOOK REVIEWS

Any scientific publication reviewed in this column may be obtained for inspection. Orders for such inspection should be directed to the Medical Library Service, 424 N. Charter Street, Madison, Wis.

New and Nonofficial Remedies, 1932, containing descriptions of the articles which stand accepted by the Council on Pharmacy and Chemistry of the American Medical Association on Jan. 1, 1932. Cloth. Price, postpaid, $1.50. Pp. 492. lvi. Chicago: American Medical Association.

The recognition of a preparation for inclusion in this book singles it out from the host of new products of the pharmaceutical manufacturers as being a worthwhile addition to the existing armamentarium of the practicing physician. To be thus distinguished it must be shown, under the impartial scrutiny of the carefully chosen group which is the Council on Pharmacy and Chemistry, that it has acceptable evidence of therapeutic usefulness and that it is marketed in accordance with the honesty and straightforwardness envisaged by the excellent Rules which have been the outgrowth of the Council's quarter century experience in appraising the merits of new drugs.

In accordance with its custom of keeping the annual editions of New and Nonofficial Remedies in

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This S.M.A. you have prescribed for my baby is a new one to me. In fact, I have never seen it advertised. But, believe me, it works like a charm and it is *so* simple to prepare—no fuss or bother at all.

Junior reaches to take the bottle right out of my hands and drinks it all up. And he's the *best* child. Always happy when he's awake, and sleeps the whole night through.

And talk about a picture of health! I believe he would take first prize in any baby contest.

I'm going to bring him down to your office Wednesday as you suggested. That S.M.A. folder you gave me says even a breast fed baby should be under the supervision of a physician and I think myself that it's better to *keep* the baby well than to wait until trouble starts.

We certainly want to thank you for bringing our baby along so well, Doctor. It increases our confidence in you as our family physician. Tom has already "said it with dollars", but I wanted to thank you personally, too.

And I'm going to persuade Mrs. Brown,—that's my neighbor with the baby that's not gaining—to come along on Wednesday so you can prescribe the proper diet for *him* too.

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the forefront of current medical thought, the Council offers in this volume the newly revised articles: Barbital and Barbital Compounds; Fibrin Ferments and Thromboplastic Substances; Liver and Stomach Preparations; Mercury and Mercury Compounds; and Ovary. Perhaps the most noteworthy new preparations admitted are: nupercaine-Ciba, a local anesthetic; pentobarbital sodium, a barbituric acid derivative; and iopax, a new preparation for roentgenologic use. All of the ovary preparations, formerly described are omitted and none of the new standardized preparations are described, although the names Theelin and Theelol are recognized in the revised general article. Another change of importance is the classification of articles formerly listed as "Exempted" under the heading "Accepted but Not Described." There is the usual excellent index and the augmented Index to Proprietaries Not Included in N. N. R.

Annual Reprint of the Reports of the Council on Pharmacy and Chemistry of the American Medical Association for 1931. Cloth. Price, $1.00. Pp. 100. Chicago: American Medical Association.

This volume contains the collected reports of the action of the Council on Pharmacy and Chemistry on all products which have been found unacceptable or which have been omitted from New and Nonofficial Remedies during the past year. It contains also the special reports authorized by the Council during the year and preliminary reports on articles which show promise but which are not yet ready for admission to New and Nonofficial Remedies nor suitable for general use by the medical profession. Among the reports on products found unacceptable are those on Thymophysin, a preparation of posterior pituitary and thymus, advocated as a safe and reliable means of accelerating delivery and marketed under false claims as to its essential action, as to its strength, and as to its safety for mother and child; on Bismuthoidal, claimed to be colloidal bismuth, and marketed with unwarranted claims of value in the treatment of syphilis intravenously; on Frenly Enema Cream, a complex, unscientific mixture, marketed under a therapeutically suggestive name with unwarranted claims of therapeutic value in a host of conditions; on Hayner's Normaline, an unoriginal preparation of formaldehyde and zinc chloride marketed under a non-informing name without a quantitative statement of composition on the label or in the advertising and with unwarranted and misleading claims; on Pernocton, a barbituric acid product marketed under a therapeutically suggestive name and with unacceptable recommendations for intravenous use; on Solution Normet, an unscientific mixture of citrates, marketed with unwarranted claims; on Alqua Water, Calso Water, and Alka Water, irrational, proprietary "alkalizing" mixtures marketed with unwarranted and misleading claims. The preliminary reports on Nucleotide K 96, a preparation of pentose nucleotides which has shown promise in the treatment of leukopenia, and on Carbarsone, p-carbamino-phenyl arsonic acid, proposed for use in amebiasis but needing further confirmatory evidence of value, are both timely and interesting. Perhaps the most noteworthy are the special reports, The Intravenous Use of Barbital Compounds and The Average Optimum Dosage of Cod Liver Oil. The former gives the Council's considered verdict on the dangers and limitations of the use of barbitals intravenously and the latter gives the result arrived at from a questionnaire sent to leading pediatricians.

Pain in the Pleura Pericardium and Peritoneum. By Joseph A. Capps, M. D., professor of clinical medicine, University of Chicago with the collaboration of George H. Coleman, M. D., assistant professor of medicine, Rush Medical College. The Macmillan Company, New York, Price $3.00.

The author presents in a clear and concise manner what is known of the cause and reference of pain originating in the pleura, pericardium and peritoneum.

It is a combined experimental and clinical study of the author's observations in a large series of cases.

Where either for diagnostic or therapeutic purposes, in human subjects, a trocar was introduced into a serous cavity,—the author introduced a silver wire with blunt point and by touching certain areas was able to demonstrate, not only whether certain areas are sensitive or insensitive, but where sensitive, the exact location of pain and its reference to other portions of the body.

He deals with each of the three serous membranes separately, reviewing briefly the anatomy, physiology and previously observed clinical data in relation to pain arising from disease of it; he tabulates the results of his observations, draws certain conclusions and at the end of each chapter summarizes our present knowledge.

At the end of the chapter on the pleura, is an excellent differential diagnosis between pain arising from diaphragmatic pleurisy and that due to inflammation within the abdominal cavity. Illustrative brief case records are introduced and numerous diagrams add to the clarity of the text.

The book is an excellent one for the student or the practitioner. R. V. V.

The Expectant Mother's Handbook. By Frederick C. Irving, A. B., M. D., professor of obstetrics, Harvard Medical School; visiting obstetrician, Boston Lying-in Hospital. With illustrations. Price $1.75. Houghton Mifflin Co., Boston.

Among numerous books on this subject this small volume is certainly among the best. Written in charmingly simple language it answers most of the questions that perplex the expectant mother and in a way that will not only remove doubt but will also establish an understanding consciousness of the problems involved. The advice offered the expectant mother is both simple and clear and thoroughly in accord with the best obstetric practice. The author

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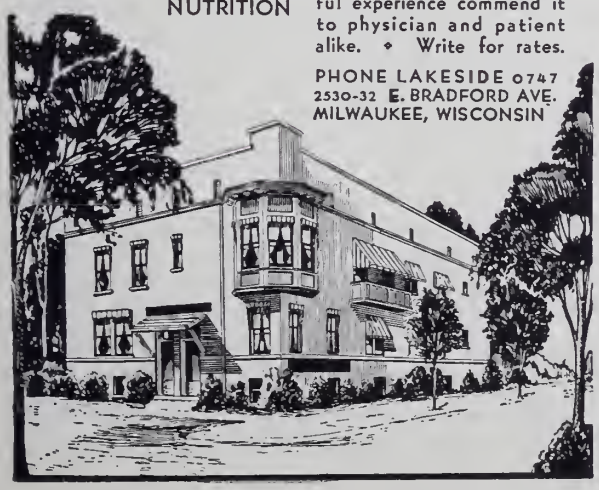

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is especially to be congratulated on the concluding chapter entitled "The Biological Aspects of Pregnancy" and dealing with such topics as evolution, heredity, determination and diagnosis of sex, twins and prenatal impressions. These subjects often are the source of much anxiety and unhappiness to the expectant mother, and the author relates all the known facts most authoritatively and in a manner that will be of much comfort to the patient.

The volume can well be recommended as a source of much useful information for the expectant mother. J. W. H.

Physician's Manual of Birth Control by Antoinette F. Konikow, M. D. 1931, Buchholz Publishing Com., 1440 Broadway, New York.

Of three recently published books on birth control for physicians, the present manual seems the most practical.

J. F. Cooper's: "Technique of Contraception" is still the classical work on the whole problem, its theoretical considerations, legal aspects and on the approved methods, which are presented together with their scientific foundations and the statistics of their comparative efficacy.

W. J. Robinson's: "Practical Prevenception," on the other hand, is a misleading book in many respects. He completely ignores follow-up research and statistics; the description of fitting occlusive pessaries to normal or displaced cervical positions is incomplete; the illustrations are blotted and do not facilitate topographical orientation; he overrates the use of contraceptive jelly and underrates the usefulness of mechanical devices; last not least, he minimizes the physician's part in diagnosing the individual conditions, which in the patient make for or against successful contraception and which render the proper fitting of the indicated type of appliance a most complicated art.

In her "Manual of Birth Control", A. K. Konikow gives a comprehensible presentation of all approved methods and procedures in practical, simple language with clear-cut illustrations. To this excellent, scientific presentation she adds her psychological experience, of teaching explicitly her patients, even those, whose personal defensiveness makes ready acceptance and cooperation difficult. This latter difficulty is one, which as yet is often overlooked in the office of the busy practitioner, who probably will welcome the method of instruction described on page 129. E. S. S.

The Costs of Medicines. The manufacture and distribution of drugs and medicines in the United States and the Services of Pharmacy in Medical Care. By C. Rufus Rorem, Ph. D., C. P. A., and Robert P. Fischelis, B. S., Phar. D. Price $2.50. University of Chicago Press, Chicago, Illinois.

This volume gives in an interesting and instructive form the relationships of the pharmacy to the patrons, with particular reference to medical supplies.

Analysis has revealed that of $715,000,000 spent by the public annually for medicines, only 27 per cent, or $190,000,000 is under the direction of physicians on prescriptions or verbal instructions. $525,000,000 represents the cost of self-medication. The "patent medicine" sales amount to $360,000,000, whereas $165,000,000 is spent for home remedies.

The average registered pharmacist fills approximately four prescriptions a day; consequently the greater proportion of his time is spent in non-pharmaceutical work as in sales services. Thus the technical pharmaceutical training of the pharmacist would scarcely seem justified by direct compensation. On this basis, the author is inclined to consider the strictly technical side of the pharmacist's work as being in the nature of public service or "public utility."

The book can be strongly recommended to those interested in public health and social service in relation to domestic economy. A. L. T.

A Manual of Pharmacology. By Torald Sollmann, M. D., professor of pharmacology and materia medica in the School of Medicine of Western Reserve University, Cleveland, Ohio. Fourth edition, thoroughly revised. Octavo of 1237 pages. W. B. Saunders Company, Philadelphia. 1932. Price $7.50 net.

This fourth edition of Sollmann's Manual of Pharmacology is an incompletely revised replica of the preceding edition. It mentions and contains references to considerable new work appearing since the completion of the previous edition. The book is exceedingly useful to students in the field of pharmacology and therapeutics.

On the side of criticism, one may say that neither the diction nor the accuracy and choice of literary citation have been improved. A. L. T.

Materia Medica, Pharmacology and Therapeutics. By Walter A. Bastedo, Ph. G., M. D., assistant clinical professor of medicine, Columbia University; consulting physician, St. Luke's Hospital, New York, St. Vincent's Hospital, Straten Island and the Staten Island Hospital; President, United States Pharmacolocial Convention, 1930–40. Price $6.50 net. Third edition. W. B. Saunders Company, Philadelphia, 1932.

This third edition by Bastedo is, like its predecessors, a very readable book. The essential features of many drugs are presented in a simple manner and are generally sound. The work is likely to be quite unsatisfactory to those students in the field who desire to review sources, since there are presented no literary references whatever and only a limited amount of authorship citation. The book might well be used as an introductory companion to a more exhaustive treatise on pharmacology. A. L. T.

Practical Treatment of Skin Diseases. With special reference to technique. By Eduard Ahlswede, M. D., formerly assistant physician, University Skin Department, direction of Prof. Unna, Eppendorf Hospital, Hamburg; assistant physician, Clinic and Research Laboratory, direction of Prof. Unna,

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Hamburg; Assistant physician, Institute of Physical Therapy, direction of O. Ahlswede, M. D., Hamburg. 77 illustrations. Price $12.00. Paul B. Hoeber, Inc., New York.

This work is a volume of 770 pages which presents not only a practical discussion of the general principles which govern in the field of dermatotherapy but in addition gives detailed descriptions of the various remedies which are to be used. Part I of the book is concerned with the general rules to be followed in the local treatment of dermatoses. Then follows a concise, efficient grouping of the more common keratolytic agents, keratoplastics, astringents, reducing agents, caustics and anesthetics. The pharmacological action of each drug is stressed with reference to its use on the skin and helpful suggestions made as to the choice of remedies in the several types of rashes.

The next section is devoted to a detailed discussion of the technique which is to be followed in the practical use of these remedies. First the technique of local treatment is explained and the point emphasized that good results are not entirely dependent on the proper choice of remedies but are also dependent on the mode or technique of their use. Secondly the several other ways of treating dermatoses are presented in the form of short chapters on internal treatment, physiotherapy, electrocauterization, actinotherapy, roentgen ray and radium therapy.

In Part II the treatment of the individual diseases of the skin is discussed. Most of the common skin disorders and some of the more unusual dermatoses are listed alphabetically and brief statements made as to their clinical characteristics. This is followed by a synopsis of the general plan of treatment indicated and by a very detailed outline of the remedies to be used and the technique of their use.

Part II is followed by several pages containing the magistral formulae of Prof. Unna. These are also arranged alphabetically and are accompanied by brief explanatory paragraphs.

The book was written in order to furnish the busy physician with a practical, efficient, manual on the treatment of skin diseases. It presents a wealth of helpful therapeutic suggestions in a relatively condensed form and in such a style as to discourage any tendency toward the use of routine methods of treatment. R. L. M.

Clinical Interpretation of Laboratory Reports. By Albert S. Welch, A. B., M. D., clinical instructor in medicine in the University of Kansas School of Medicine in Kansas City, Kansas; director of the laboratory of the Alfred Benjamin Dispensary, and attending surgeon of St. Joseph's Hospital in Kansas City, Mo. Sixteen illustrations. Price $4.00. P. Blakiston's Son & Co., 1012 Walnut Street, Philadelphia.

This book of 332 pages is devoted entirely to a discussion of the diagnostic significance of the results of clinical laboratory examinations. There is no description of tests and laboratory technique. The comments on the interpretation of laboratory findings are brief and to the point and will be found to be helpful to those who are not familiar with the limitations and fallacies of laboratory methods. It is to be regretted that there is not some discussion of the pathology which the tests are devised to reveal. Such a discussion would make more understandable the limitations pointed out. The book, however, will be found to be instructive and helpful in the interpretation of laboratory reports. W. D. S.

PRESS SERVICE

(Continued from page 569)

of age suffering any serious dangers from excessive weight.

"Some people look on fruit as a luxury, but there are very good reasons why we should eat fruit daily," declares the health bulletin. "All fruits contain certain salts of organic acids which have a more or less stimulating action on the kidneys, and some of them such as pears, figs, and prunes have a laxative effect. In addition to this, fruit furnishes a certain indigestible bulk or roughage which tends to retain water in the intestines and thus helps to regulate the functional movements.

"Children's physicians recommend that all babies of the age of six months should be given small amounts of mild fruit juice or tomato juice daily. This is particularly necessary in the case of infants fed on cow's milk or other prepared milk foods. Unless one of these juices is given, a disease known as scurvy may develop. The mild form of this disease often passes unrecognized for a time, being noted only in a slowing up of the growth of the child later on.

"Fruit is one of the so-called 'protective foods,' and should be used in some form daily. Fresh fruits, because of their large content of water, are always cooling, refreshing and appetizing. Fruit, which is not thoroughly ripe, or is decomposed, should not be eaten.

"Bananas are a staple fresh fruit, high in fuel value, low in price and easy to prepare. Digestive difficulties usually arise from eating them too green, too fast, or from eating too many. They are most digestible when fully ripe (that is when the skins have darkened, and the fruit is soft and yet firm). They are usually cheaper this way, because the merchant knows they will not keep long afterwards. Bananas baked or stewed and mashed, flavored with lemon and sugar are very palatable. Unripe bananas baked in the skin may take the place of a vegetable at a meal.

"Next to bananas, apples are our most abundant market fruit. Their many and varied uses are too well known to require comment.

"When we chew fibrous food, such as raw fruit, it is said that we exert a pressure of from 100 to 150 pounds on the teeth. This aids in good circulation of blood, and in children, undoubtedly, develops teeth and jaws. Raw fruit also leaves the teeth freer from adhering matter than do soft foods. Hence it is wise to end a meal with raw fruit, since it not only acts as a cleanser of the teeth, but it also helps to preserve them by stimulating the secretion of a strongly alkaline saliva which coats the teeth and counteracts the effect of particles of food which would otherwise remain."

• • •

WATER HAZARDS

Madison, Wis., July 21.—Swimming fatalities could be reduced in number if bathers would follow simple health rules. Too many people go swimming when overheated and others with no knowledge of the waters, declares the Educational Committee of the State Medical Society in its weekly bulletin issued today. There were 219 drownings in Wisconsin in 1931.

PHYSICIANS' EXCHANGE

Advertisements for this column must be received by the 25th of the month preceding month of issue. A charge is made of $2.00 for the first appearance of copy occupying 1 inch or less of space and $1.00 for each succeeding insertion of the same copy. Kindly accompany copy with remittance to cover number of insertions desired. Advertisements from members of the State Medical Society will be accepted without charge. Such copy will be taken out after its second publication unless otherwise requested. Where numbers follow advertisements replies should be addressed care Wisconsin Medical Journal.

FOR SALE—Mobile Victor x-ray unit (in Milwaukee) either AC or DC currents, with 30 MA tube, including all dark room equipment and accessories. Practically new. Will sell at less than half the present market price. Address No. 881 in care of the Journal. JAS

FOR RENT—Office space for general practice above a corner drug store, in a residence neighborhood in Milwaukee. Dentist and oculist on same floor. Rent very cheap. Call Marquette 0217.

FOR SALE—Office equipment, practically new. Hanovia quartz ultraviolet lamp; diathermy; zoalite lamp; office furniture, accessories, etc. Mrs. John Freedman, 2679 N. Teutonia Ave., Milwaukee. Telephone Hopkins 0739. JJA

FOR SALE:—10″ direct current x-ray machine; dental chair, and Morse wave generator. Dr. Philip Eisenberg, 808 N. Third St., Milwaukee. Phone Marquette 0952.

WANTED: Used diathermy, Morse wave generator, infra red and quartz lamps, electric centrifuge, colorimeter and skeleton or parts. C. J. Yeager, 4 S. Genesee St., Waukegan, Illinois. ASO

WANTED—Position by physician of 25 years experience to take practice of some physician who contemplates a six month's or a year's absence from his practice. City preferred but would consider country practice. Address number 878 in care of the Journal. JJA

WANTED—Used Balkan Frame complete with trolleys. Price should be very reasonable. Also, special fracture bed. Address "N", 2424 W. Kilbourn Ave., Milwaukee. Tel. West 0687.

FOR SALE—Established practice in central Wisconsin. Widow desires to dispose of complete office and ophthalmological equipment for a reasonable figure. For further information address No. 882 in care of the Journal. ASO

WANTED—Locum tenens work by capable physician; available for short or long period; Wisconsin license; references; will not compete. Address number 851 in care of the Journal.

MATERNITY HOME for unfortunate girls. Secluded, private. Rates reasonable. For information write to Box 120, R. R. 5, Baraboo, Wisconsin.

FOR SALE: X-Ray apparatus, motor driven tilt table KK, Bucky diaphragm, 5″ gap, 30 M.A. x-ray machine, x-ray filing cabinet, basal metabolism machine, home model quartz lamps, infra red lamps, cassettes and screens. Will sell separately. Diagnostic Laboratories, Waukegan, Illinois. ASO

FOR SALE—Complete hospital equipment for 12 beds, operating room, x-ray, sterilizers, steel cabinets, safe, etc., all in perfect condition and ready to operate. For further information address Mrs. G. C. Buck, Platteville, Wis. ASO

FOR SALE—Will sell for cash the following: Standard x-ray transformer, volts, 220, amp. 25, style D, No. 811, in perfect condition $200; two gas x-ray tubes and two Coolidge tubes for transformer, cost $400, will sell for $60; one Victor stand screen, cost $125, will sell for $40; one Fischer x-ray tube holder, cost $85, will sell for $25; hospital beds and mattresses, $5.00 and up; hospital pillows, 25¢ each and hospital bedding equally cheap; surgical instruments and all hospital equipment for less than half price. Everything in good condition. Address number 879 in care of the Journal. JAS

EXCELLENT LOCATION—In the northeastern part of the state, fifteen miles by concrete to hospital. Widow desires to dispose of location including office equipment, office and residence. Will consider renting. Address No. 866 in care of the Journal. ASO

FOR SALE—Eye, ear, nose and throat practice in Milwaukee. Best location in city. Established 20 years with many connections and cooperation of leading optometrists. Will introduce buyer. Leaving city on account of death in family. An exceptional opportunity to acquire a fine going special practice. Address No. 880 in care of the Journal. JAS

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Five simple rules will save many lives, the bulletin says.

1. Do not go into the water when overheated. Failure to observe this rule may cause cramps.
2. Do not swim immediately after eating. An interval of at least two hours should elapse.
3. Do not swim until over-tired. When this is done the splendid tonic effects of swimming are lost and an undesirable reaction is substituted.
4. Do not loll in the water for several hours at a time. To obtain the beneficial effects of a swim one should remain in the water no longer than thirty minutes at a time.
5. Do not follow the practice of "drying off" in a chilly atmosphere. Take a brisk rub after each swim and change into dry clothes instead of allowing the clothing to dry on the body.

"Although swimming is one of the finest of all recreations, the safe and sensible swimmer is quick to recognize that a number of health hazards are associated with swimming which should be known and avoided," continues the bulletin. "Neglect in guarding against these hazards may result in serious injury to the swimmer's health and may even result in endangering his life.

"Too few persons attempt to acquaint themselves with the sanitary environment or quality of the water in which they swim. There is a blind trust in the supervisory authority of an official, supposedly on constant watch."

THE NURSE IN INDUSTRY

(Continued from page 568)

Committee. After preliminary correspondence and after each committee member had endeavored to work out those suggestions that seemed apropos, the Committee met twice as a whole. After a final conference the Secretary four times submitted drafts to the Committee and other changes were subsequently suggested by the Council before the orders were finally approved.

The Committee recognized at once that there was not only a place for the nurse in industry but that there was a real need in all the larger establishments for such a supplementary service. The Committee was of the opinion that, well directed, the nurse might not only be helpful in the matter of nursing service for the sick but that she had a place and a distinct one on the economy side with respect to the insurer and her employer. They were of the opinion, however, that her services could only be regarded as supplementing those of the physician in the field of treating the sick and that it was not only a false economy but a betrayal of the injured and sick to offer her efforts as a substitute for the attention of the physician and surgeon. As was so well said by the late Dr. A. B. Rosenberry of Wausau, then Medical Director of the Employer's Mutual Liability Insurance Company, "high class service is always the best for the injured and the most economical for the company."

Your Committee and officers did not anticipate that your suggestions would be found to be perfect in all respects. As defects are pointed out the Council will issue, from time to time, revisions that the services of the nurse in industry may be of such type as will be in keeping in every respect with the high ideals of that profession. It is also to be noted that while the Council sent a copy of the orders to all nurses known to be employed in industry, these orders after all are but suggestions to the plant physician and subject to his approval before they are effective. At all times the orders are subject to his modification and control.

Standing Orders for Nurses in Industry Receive Wide Attention

That the State Medical Society pioneered in issuing its suggested standing orders for nurses in industry is evidenced by the fact that the Society is now receiving requests for copies of the orders from points throughout the country.

"I believe that the State Medical Society of Wisconsin," writes Dr. C. O. Sappington, director of the division of industrial health of the National Safety Council, Chicago, "is to be congratulated upon starting and making a definite step in a procedure which will undoubtedly become general throughout the country."

Letters expressing interest and appreciation and asking for copies were received during the month from the following:

Catherine C. Cushing, R. N., Nashua Gummed & Coated Paper Co., Nashua, N. H.

Mabel Carlson, R. N., Johns-Manville Corp., Manville, N. J.

Mr. J. W. Becker, Executive Secretary, Missouri Tuberculosis Association, St. Louis, Mo.

Georgianna Bergen, R. N., The Seamless Rubber Company, New Haven, Conn.

Celia Atkinson, R. N., Ruberoid Mills, Joliet, Ill.

(Continued on page 582)

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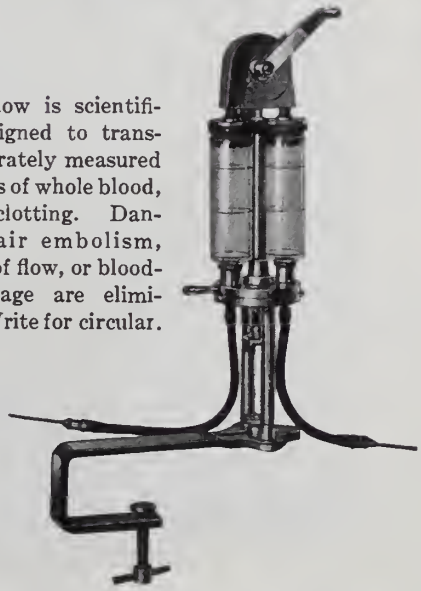

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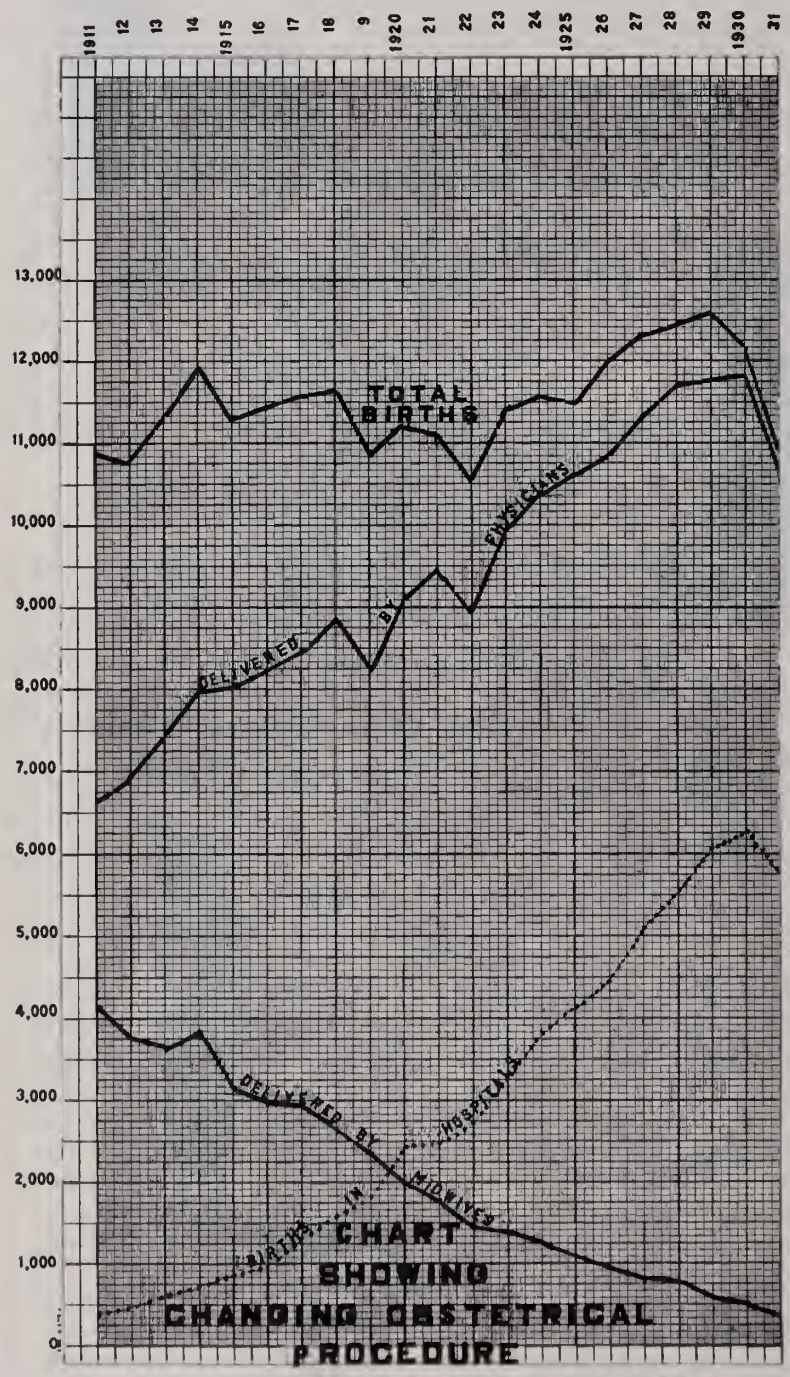
Changing Obstetrical Procedure in Milwaukee

By J. P. KOEHLER, M. D.
Health Commissioner, Milwaukee

An interesting picture of the changing trends in obstetrical procedure in Milwaukee is shown on the chart accompanying this article. In the early days of Milwaukee the major part of obstetrical service was provided by midwives. This is shown by the fact that in 1895 of 7813 babies born, 6567 were delivered by midwives and only 1246 by physicians. The number of confinements by midwives has steadily decreased with, of course, a steadily increasing number cared for by physicians until in 1931, with a total of 10,864 births, only 392 were cared for by midwives.



The number of deliveries of babies in hospitals in the early days of the city was extremely small and, in fact, so small that no record of hospital deliveries is available until the year 1911 when 302 babies were born in hospitals. Again this number has steadily increased until 1931 when 5753 births occurred in hospitals, or more than 50% of all babies born in the city are now born in hospitals.

This change in procedure is reflected by the changed infant death rates. In 1893 the infant death rate was 366 per 1000 births; in 1905, 139 per 1000 births, and in 1931 has dropped to 57 per 1000 births.

Of course, decreased death rates are not solely attributable to this change in procedure, but undoubtedly improved obstetrical practice is a major factor in the conservation of infant lives.

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Medical Science Course The medical science course covers two years of college work in English, foreign language, physics, chemistry and biology and two years of work in the basal medical sciences, anatomy, histology, neurology, physiology, physiological chemistry, pathology, bacteriology, pharmacology, hygiene and diagnosis. This course leads to the B. S. degree.

Medical Course At least two years of college work, including English, foreign language, physics, chemistry and biology, are required for admission. The course requires at least four years for completion. During the first two of these years the work lies chiefly in the basal medical sciences outlined above. The third year of the course is devoted to didactic and practical instruction in the wards and out-patient department of the Wisconsin General Hospital. The fourth year of the course is devoted to practical instruction under the supervision of preceptors in the Wisconsin General Hospital and in affiliated institutions.

Courses in Nursing Courses in nursing are offered in the School of Nursing affiliated with the medical school. A residential course of 32 months is offered in the Wisconsin General Hospital to those who have completed a semester of specified work in the College of Letters and Science. This course leads to a certificate of graduate nurse. A residential course of 27 months is offered to those who have completed three years of college work in specified subjects either in the College of Letters and Science or in the Department of Home Economics. These courses lead to a certificate of graduate nurse and to a B. S. degree.

Graduate Courses Opportunity is offered for graduate work in the preclinical and the clinical medical sciences and in hygiene and public health. For further information address C. R. Bardeen, Dean, Medical School, Madison, Wis.

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Instruction The course of instruction extends through a period of five years and leads to the degree of M. D., the fifth year being devoted to hospital internship. Each annual session begins the first of October and ends about the middle of June. Particular emphasis is laid upon practical work in the anatomical, chemical, physiological, pathological, and surgical laboratories. A dispensary is maintained by the Medical School, in which ample opportunity is afforded for practical instruction in all branches of medicine and surgery.

Clinical Facilities Medical and surgical clinics are conducted in Milwaukee County Hospital, and in a number of city hospitals, thereby affording adequate facilities for imparting bedside instruction under scientifically competent and experienced staffs.

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(Continued from page 578)

Carolyn Conner, R. N., Quaker Oats Co., Akron, Ohio.

Dorothy E. Wiesner, Statistician, Philadelphia Health Council and Tuberculosis Committee, Philadelphia, Pa.

Mr. Jacob A. Goldberg, Secretary, Industrial Hygiene Committee, New York Tuberculosis and Health Association, New York, N. Y.

Laura S. Pratt, R. N., National Blank Book Co., Holyoke, Mass.

Ethel M. Howard, R. N., Housatonic, Mass.

Emma C. Lake, R. N., Perry County Health Unit, Marion, Alabama.

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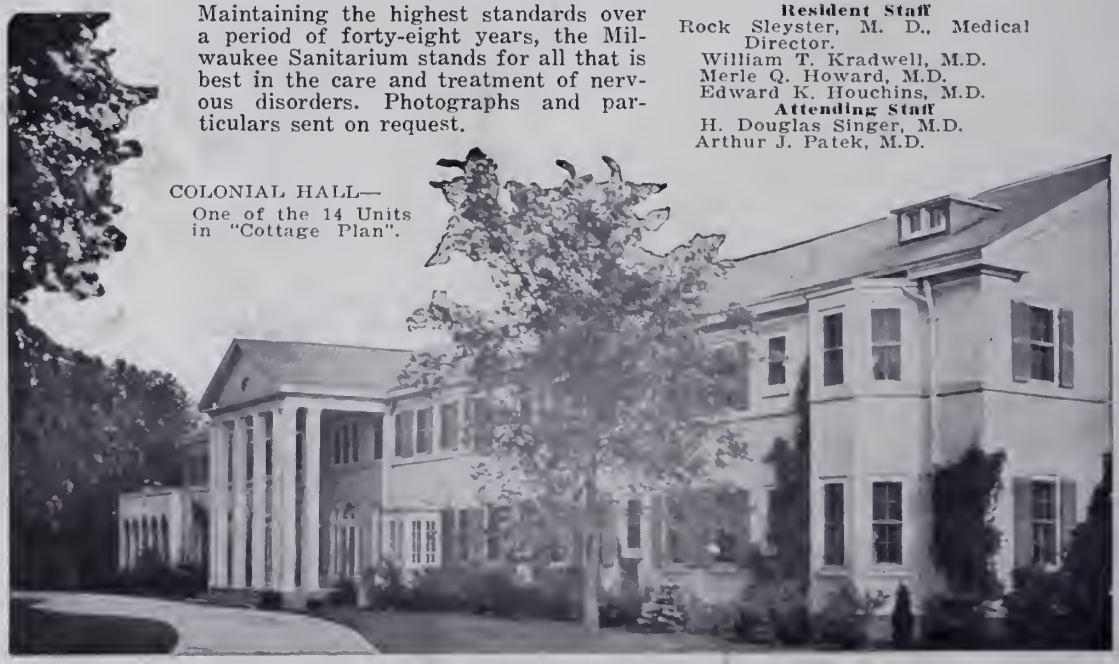

September 13th to 16th. See page 647

THE WISCONSIN MEDICAL JOURNAL

STATE MEDICAL SOCIETY OF WISCONSIN — MEDICINA NUSQUAM NON EST

Owned and Published Monthly by the State Medical Society of Wisconsin
J. G. CROWNHART, Secretary-Managing Editor

VOLUME XXXI
NUMBER 9

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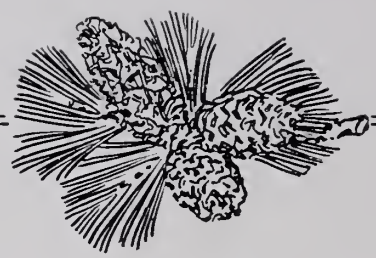

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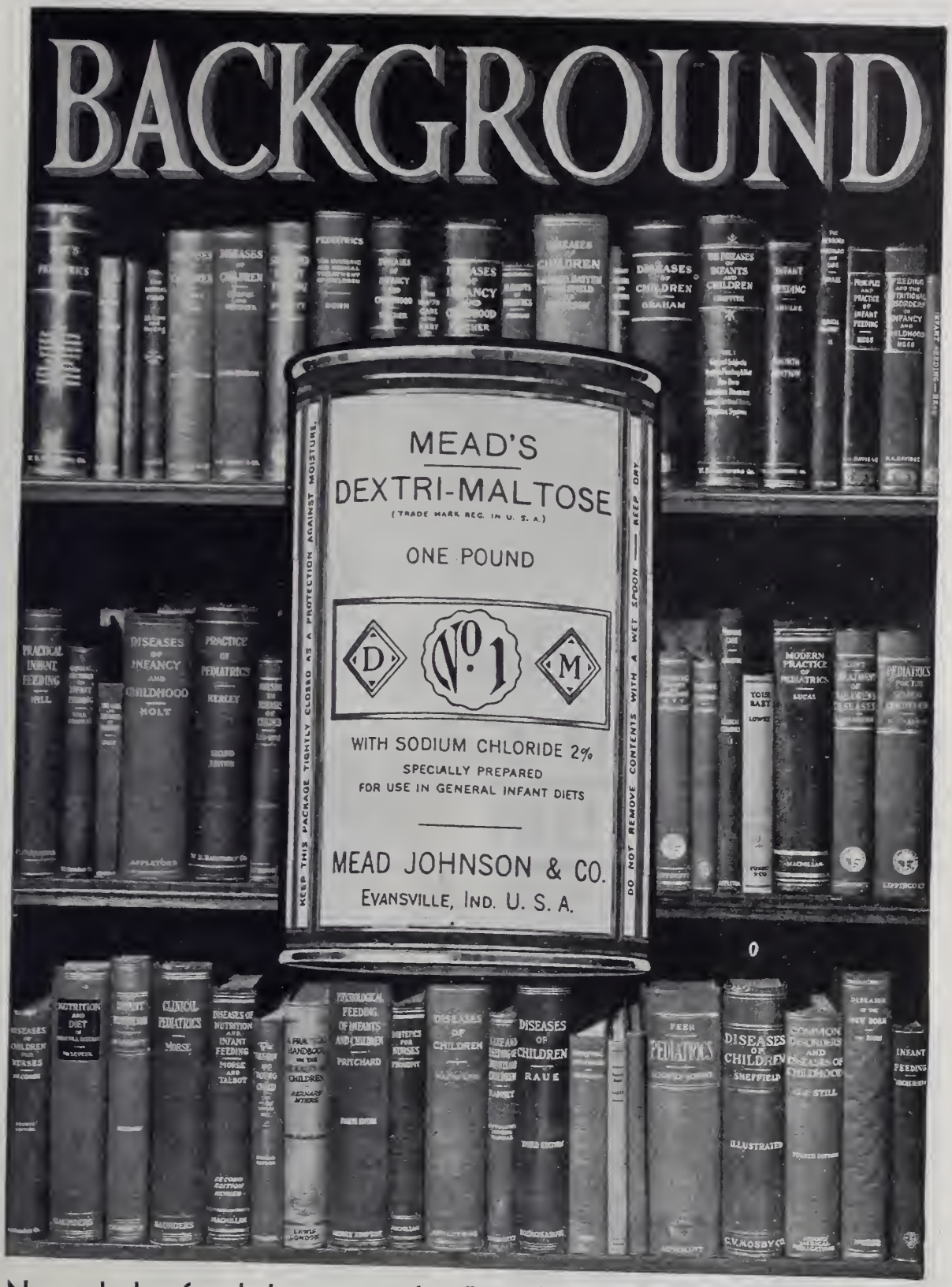

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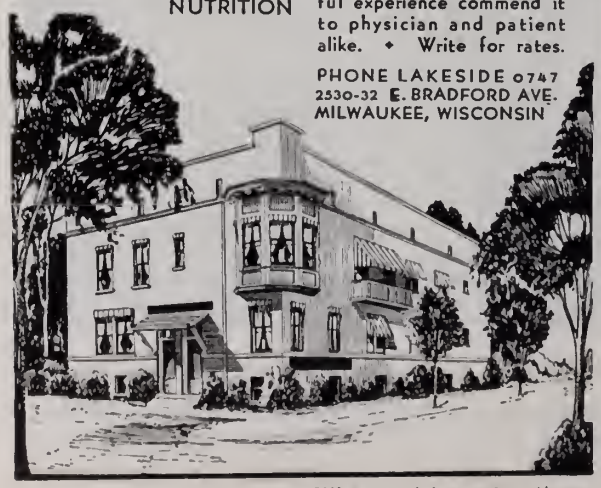

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The Wisconsin Medical Journal

Volume XXXI SEPTEMBER, 1932 No. 9

The Wisconsin Cancer Survey; A Preliminary Statement

By W. D. STOVALL, M. D., Director
State Laboratory of Hygiene and Chairman
Committee on Cancer, State Medical Society of
Wisconsin, Madison

The increasing death rate from cancer and the declining death rate from communicable diseases has emphasized the necessity for making a drive on this most important cause of death and the success which can be obtained by cooperation between the profession and the public.

Only a few official public health agencies have given any thought or attention to cancer. European countries have been more active. The government of Sweden over fifteen years ago sensed the coming importance of radium and x-ray in the treatment of cancer and purchased a large amount of radium which was used under the direction of able men. The government institute in Sweden is the leading cancer therapy institute in the world and their reports are the most authentic matter on the use of radium and x-ray in the treatment of cancer. The New York institute for the study and treatment of cancer ranks first among the state institutions as a research laboratory, a tissue diagnostic clinic and as a radium and x-ray center.

The American Society for the Control of Cancer, organized in 1913 by a group of philanthropic lay and professional men and women, state the problem of cancer control, broadly speaking, to consist of (a) education which involves the advancement and the dissemination of knowledge regarding cancer both among the general public and the medical profession, (b) research, which involves a study into the nature and cause of cancer, and (c) treatment, which includes the establishment of diagnostic facilities and provision for the care of the sick. The American society early in its history concentrated its efforts upon the dissemination of information to the general public. The State Medical Society contributed enthusiastically to this activity, and ten years ago appointed a cancer committee which organized the profession for the dissemination among the public of cancer control information.

Due to advances in science, the technique for the diagnosis and treatment of cancer has undergone a great change. The principles for the surgical treatment of cancer were developed as early as 1895. Anti-sepsis, brought about by bacteriological study, had wiped out the dangers of infection; anesthesia had destroyed the associated pain. There then remained only the training of men and women, the construction of hospitals and organization of hospital staffs for the application of this technique.

This development had all taken place by 1915. Cancer at that time (1915) was always seen late. The patient came to the physician after the diagnosis was obvious to a layman and when the surgeon could make his own diagnosis by gross inspection of the tissue. A microscope was not, in general, part of the diagnostic equipment of the operating room. Lay education is now bringing many patients to the physician's office early in the history of suspected cancer lesions. Because of this the difficulties of diagnosis have been increased. Old surgical methods of physical examination of the patient and gross examination of the tissue is no longer sufficient. It is often necessary to biopsy for microscopic examination rather benign appearing lesions in order to determine the nature of the tumor. Clinical knowledge concerning the behavior of malignant tumors has also added to the importance of microscopic examination of tissue. Some malignant tumors are less malignant than others and some are more susceptible to modern methods of treatment than others. These differential diagnostic feat-

ures are revealed through the microscope to capable pathologists. The microscope is, now, a necessary instrument in operating room equipment and the pathologist an important member of the operating team.

Changes in therapy of equal importance with changes in diagnostic methods have been brought about with the advent of radium and x-rays. It is now recognized that cancer of the mouth, skin and cervix can be treated, in general, more effectively with radium or x-ray than with surgery. It is also recognized that by the proper choice of treatment the best interest of the patient is served. It is not always a choice between radium, x-ray or surgery but a choice of combinations of these remedies. This has added radium and x-ray to the operative equipment needed for the treatment of cancer, and another expert, the roentgenologist, to the operating team.

While this seems very complex and to almost, if not completely, remove the advantages of modern methods from the cancer case which does not live near a cancer clinic or a large medical center, it is not an insurmountable barrier. It does mean that the medical profession must solve a difficult problem—difficult because it touches so many conflicting human interests and the interests of so many different specialists. The remedy, however, is apparent. The medical schools must train more men to be roentgenologists and pathologists. The medical schools, however, will not succeed as long as the traditional attitude of the old time clinician maintains. That is: As long as the roentgenologist and pathologist are put outside the realm of clinicians and are considered as assistants to take orders rather than as colleagues with whom to consult. There can be no far reaching extension of modern cancer treatment into small communities until this is changed.

It, therefore, seems obvious that it is necessary to disseminate information among the profession as well as the laity. The laity has been getting all of the attention until now. The cancer committee feels that the most important service the State Society can render is to provide a way by which recent advances may be disseminated among the profession and by which technical improvement may be actually applied.

With these ideas in mind it became necessary first to know the exact status of the profession in respect to facilities for properly handling cancer cases. In order to ascertain these facts the council invited the American Society for the Control of Cancer to make a survey of the facilities in the state for the diagnosis and treatment of cancer. This report compiled by Dr. Rector is of interest to every physician. The recommendation of the cancer committee (Wis. Med. Jr., Aug. 1932, page 566) are also important to every physician for their active cooperation is necessary to the success of the committee's plans. It is hoped that this report will be stimulating and the initial plan suggested by the committee will secure the hearty support of the hospitals and the profession throughout the state. The committee realizes that the initial step is short. We cannot, however, encompass the whole problem of cancer control in the beginning. The chief purpose, now, is to initiate a central tumor registry which will be a source of information for those who wish to improve their technique for handling cancer and a service for those who need it for the microscopic diagnosis of tumors. By this the committee does not mean to suggest that the older field of activity, public education, be neglected. The importance of this endeavor has been recognized in the recommendations.

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Adopting with modification the report of the Committee on Medical Economics, the Medical Society of the State of New York has issued the following statement as presenting its official position in the matter of fee-splitting.

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Cancer Survey of Wisconsin, 1931

Made by the
American Society for the Control of Cancer
New York, N. Y.
Clarence Cook Little, Sc. D.
Managing Director
Prepared by
FRANK LESLIE RECTOR, M. D.
Field Representative

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INTRODUCTION

The increasing mortality from cancer makes it a disease of the first importance to the general public and to the profession. The unknown etiology and the relatively small percentage of cures compared with the number of patients treated make cancer the greatest challenge to medical science today. The disease is of compelling interest to both the medical profession and the laity.

This interest is finding expression in various ways. The laity is asking more insistently for reliable information and advice about the disease. The public is eagerly studying authentic educational facts for an explanation as to cause and cure. The medical profession is also inquiring into its responsibility to the public regarding cancer and is beginning to organize its resources for a more determined and effectual attack on this baffling problem.

While certain facts are well known about the cancer problem in general, there is a great paucity of information about specific phases of the problem. This information is lacking especially in regard to the facilities available for adequate cancer diagnosis and treatment, as to where such facilities may be found, also where they may be lacking. Such information can be obtained only by careful surveys of hospitals, clinic groups, and other organizations concerned with the cancer problem.

The State Medical Society of Wisconsin, known for many years for its progressive approach to the study of medical and health problems, has given further evidence of its interest by declaring officially that the cancer situation in that state should be investigated in order to determine if a more adequate program of medical care could be developed. On January 3, 1931, the Council of the Society passed a resolution in which the American Society for the Control of Cancer was asked to undertake a survey of the cancer situation in Wisconsin, reporting

its findings with recommendations to the Medical Society. The action of the Council in this matter and the resolution adopted were reported in the Wisconsin Medical Journal on pages 118 and 119 of the February, 1931, issue as follows:

"COMMITTEE ON CANCER: The following report of the Committee on Cancer was presented by Chairman W. D. Stovall and upon motion by Connell-Pope, was accepted as to its recommendations:

"TO THE COUNCIL:

This committee has for several years been actively engaged in an educational campaign to inform the public on the menace of cancer and how to some extent it may be controlled. The educational work has consisted of the distribution of literature and public lectures on the early recognition of cancer with the recommendation that a physician's advice be sought early.

"This campaign has resulted in arousing a widespread interest in the subject and has been to some extent responsible for the increased activity of scientific investigation into the cause, diagnosis and methods of treatment of cancer. The interest of the public has been so aroused that men of wealth have been willingly giving large sums of money to support all phases of the work. State and city governments have in many instances appropriated money for the purpose of the advancement of research into the cause, diagnosis and treatment of cancer.

"In this state, so far, no definite plan has been formulated either by the state or medical profession to meet the cancer problem. The committee is, therefore, convinced, because of the importance of the problem and because of the experience in other states and in other cities throughout the country, that we should not be inactive on this problem.

"The committee, therefore, recommends:

(1) That a sum of five hundred dollars be set aside for expenditure by this committee to be used to advance the technical skill of physicians throughout the state in the recognition and treatment of cancer. Already the question is being asked: Are the rank and file of physicians sufficiently informed on the difficult problems involved in the diagnosis and treatment of cancer to care for the cases that are being sent to their offices by the lay educational campaigns conducted by various private agencies? Some of this money we would spend for a cancer exhibit and clinic for the annual meeting. The rest would be used to solicit funds for broadening this activity and for lay educational work as the advancement of information warrants.

(2) The committee further recommends that the American Society for the Control of Cancer be invited to make a survey of the facilities in this state for the care of cancer patients and the study of the disease. In order to officially bring this request before the American Society for the Control of Cancer, we suggest the adoption of the following or similar resolutions:

"WHEREAS, The rapid increase of cancer in its various forms is assuming alarming proportions, now being second only to heart disease as a cause of death; and

"WHEREAS, The present cancer situation is a challenge to the medical profession to render an increasingly effective service in its diagnosis and treatment; and

"WHEREAS, The greatest hope for reducing the increasing mortality from this disease lies in diagnosis and treatment in early stages; and

"WHEREAS, The medical profession and the hospitals are the only forces capable of coping with the cancer problem at this time; and

"WHEREAS, There is need for further education of the medical profession and the public as to the need for and value of early diagnosis and early adequate treatment; and

"WHEREAS, A constructive program of improved cancer service can be based only on accurate information as to the present professional and institutional facilities for the diagnosis and treatment of this disease; therefore, be it

"*Resolved*, That the Council of the State Medical Society of Wisconsin approve and sponsor a survey of the cancer situation in Wisconsin, and that the American Society for the Control of Cancer be requested to make such a survey, reporting its findings with recommendations to this Society.

Respectfully,

W. D. STOVALL, M. D.,
Chairman."

With very few exceptions the field work of this survey has been carried out with the fullest cooperation of hospital executives, medical staffs, health departments, both state and local, and many other organizations. The officers and executive staff of the State Medical Society have given enthusiastic support to the work. The State Commissioner of Health placed the facilities of his department at our disposal and the Division of Vital Statistics of that department has supplied the material for most of the statistical tables incorporated in this report. The Medical School and Extension Division of the University of Wisconsin responded generously to requests for information and advice on various problems connected with the survey. The Medical Department of Marquette University gave generous assistance to the work. The records of the Milwaukee Department of Health and the Milwaukee Visiting Nurse Association

were made available freely to the field worker. The Wisconsin Anti-Tuberculosis Association contributed of its experience and information to the problem.

Without the cooperation of the above mentioned individuals and organizations, this survey would not have been possible, and it is a pleasure to here recognize and acknowledge their interest and assistance in this work.

METHODS OF THE SURVEY

Previous to undertaking the detailed investigations, a preliminary visit was made to Wisconsin and the work of the survey discussed with individuals and organizations most concerned with it. Shortly before the field work was begun, the following questionnaire and covering letter were sent to all hospitals in Wisconsin with a listed capacity of fifty beds or more, asking for information regarding bed capacity, equipment, methods of handling cancer cases, and statistics of their cancer experience during the previous year:

"June 3, 1931.

"Upon request of the State Medical Society of Wisconsin, the American Society for the Control of Cancer is undertaking a survey of the hospital and medical facilities in that state for the diagnosis and treatment of cancer.

"This survey will bring together for the first time in Wisconsin information as to existing facilities for the diagnosis and treatment of cancer in its various forms, and should prove of benefit alike to the general community and those primarily interested in this disease.

"From the data assembled a report will be prepared for the medical society with recommendations.

"In order that this survey may be as comprehensive and valuable as possible, your cooperation is earnestly requested. The enclosed questionnaires, one copy being for your own files, require a minimum of statistical work, the majority of the questions being answered by yes or no.

"It would be greatly appreciated if the completed questionnaire could be returned in the enclosed envelope not later than June 25, next.

"Anticipating your cooperation in this important work, I am,

"Sincerely,

F. L. RECTOR, M. D.,
Field Representative.

"Enclosures: Two questionnaires, self addressed stamped envelope."

"AMERICAN SOCIETY FOR THE CONTROL OF CANCER
25 West 43rd Street, New York, N. Y.

HOSPITAL SURVEY OF CANCER FACILITIES IN WISCONSIN

1. Name of Hospital.
2. Address of Hospital.
3. Superintendent's name.
4. Total number of beds (excluding bassinets)
5. Number of beds available for cancer patients.
6. Maximum voltage of x-ray machines.
7. Number of milligrams of radium owned by hospital.
8. Has hospital a radium emanation plant?
9. Does hospital rent radium? Purchase radon? From where obtained?
10. Have you a laboratory properly equipped for tissue examination? For making frozen sections for quick diagnosis during operation.
11. Is the pathologist in charge a physician?
12. Is the pathologist on full or part time service?
13. If part time, how many hours daily or weekly is he in attendance?
14. If there is no laboratory, where are tissues sent for examination?
15. Is the hospital affiliated with a teaching institution?
16. Which, if any, staff members specialize in treating cancer? What particular form or forms?
17. Have you and Out-Patient Department equipped and staffed to diagnose cancer?
18. Number of cancer patients in Out-Patient Department in 1930.
19. Are cancer patients subjected to group study by staff?
20. Has hospital a social service department?
21. Is the status of all cancer patients known five years after discharge?
22. How much money was spent in cancer research in your hospital in 1930?
23. Do you need additional funds for cancer work? If so, how much and for what purpose?
24. Number of adult patients admitted to hospital in 1930.
25. Number of cancer patients admitted to hospital in 1930.
26. Names of staff members attending these patients.
27. Number of all hospital deaths in 1930.
28. Number of cancer deaths in 1930.
29. Number of autopsies performed in 1930.
30. Number of cancer autopsies performed in 1930.
31. An EARLY CASE OF CANCER is designated as one in which the lesion is undoubtedly local, with no apparent extension to deeper structures and with no enlargement of adjacent lymph nodes.

How many cases of *early cancer* were admitted to your hospital in 1930?

Signed by _____

Date_____ Official position _____"

Each hospital contributing to the survey was visited by the Society's Field Representative and cancer problems discussed with

the superintendents and such staff members as were available. The physical equipment of the hospital, particularly the surgical, pathological, and x-ray equipment were inspected.

Some time was spent discussing cancer problems with the different physicians known to be particularly interested in cancer work. Hospital staff meetings were also attended and different phases of cancer work discussed with those present.

The collected information and statistical material have been analyzed and form the body of this report.

HISTORICAL

The region now comprised within the boundaries of Wisconsin was first visited by the French who established a mission near the mouth of the Fox River in 1669. The country was rich in fur-bearing animal life and it was largely the opportunity for collecting furs as well as the spirit of exploration and religious adventure that brought the earliest white men to this region.

In 1787 the Northwest Territory, which included Wisconsin, was established. The division of this region into states began soon after its formation and in 1836 Wisconsin became a separate Territory including Iowa, Minnesota and parts of the Dakotas. The limits of Wisconsin Territory were gradually reduced until 1848 when, with its present boundaries, it was admitted to the Union.

The State Medical Society of Wisconsin was chartered by the Territorial Legislature in 1841 and with the exception of the first three or four years of its existence, and for two years during the Civil War, this Society has held an annual meeting. Throughout its history, this Society has taken an active part in the progressive movements of medicine and public health. It sponsored the enactment of legislation creating institutions for the proper care of the feeble minded and the insane. After petitioning several successive legislatures, it secured the enactment of a law creating the State Board of Health in 1875 and has ever since taken an active and constructive interest in the work of the Board. Early in its history the Society secured the passage of laws protecting the public against the frauds and quacks who prey upon the credulous sick. The weight of its influence was brought to bear in securing the passage of legislation establishing state institutions for the care of the tuberculous.

Realizing the necessity for better medical education, the State Medical Society was largely responsible for the introduction of a two-year medical course at the University of Wisconsin. It has cooperated with the Extension Division of the University in the organization of courses for practitioners of medicine in their home communities. It issues regularly to the public, through the lay press of the state, authentic and timely information on health and medical questions.

There are in the state at this time more than 3,000 licensed medical practitioners, or one to each 970 of the population.

STATISTICS

Population

According to the Federal Census for 1930, Wisconsin has a population of 2,939,006. Of this number 1,553,843, or 52.8 per cent, are classified as urban and 1,385,163, or 47.2 per cent, as rural. The southeast quadrant of the state is the most densely populated and contains the largest number of factories and industrial workshops. The remainder of the state is largely rural with agriculture and dairying the major occupations.

There is a large admixture of foreign stock in the population of the state. The following foreign countries are each represented by two per cent or more of the 1930 population: Germany, Poland, Norway, Sweden, Czechoslovakia, England, Canada, Denmark, Ireland, Russia, Austria and Italy.

The population also includes 10,739 Negroes, 11,548 Indians and 2,396 Mexicans.

The number of illiterates in the State is comparatively small, the 1930 census revealing but 44,232 individuals ten years of age and over, or 1.9 per cent, who are unable to read and write.

I. POPULATION OF WISCONSIN BY DECADES

Year	Population Total	Urban	Rural
1840	30,945	--------	--------
1850	305,391	--------	--------

1860	775,881	--------	--------
1870	1,054,670	--------	--------
1880	1,315,497	--------	--------
1890	1,693,330	562,286	1,131,044
1900	2,069,042	790,213	1,278,829
1910	2,333,860	1,004,320	1,329,540
1920	2,632,067	1,244,568	1,387,499
1930	2,939,006	1,553,843	1,385,163

With the exception of Milwaukee, Racine, Madison and Kenosha, there are no cities in the state of more than 50,000 population. There are nine cities with a population of between 25,000 and 50,000, fourteen with a population of between 10,000 and 25,000. Twenty towns have populations from 5,000 to 10,000 and thirty-six others have from 2,000 to 5,000 inhabitants each.

In keeping with a majority of other commonwealths, and with the United States as a whole, the population of Wisconsin is gradually but consistently becoming an older population. This is particularly true in the age groups above thirty. There is a distinct loss in the percentage of population under twenty years of age and a distinct gain in the population from thirty years of age and upward. This fact is again demonstrated when the age distribution of the population for 1930 is compared to the age distribution of the standard million population familiar to statisticians. In the accompanying table the real population of Wisconsin for 1930 has been compared on the basis of the standard million distribution with the result that up to age thirty-five the real population age grouping is below that of the standard million while the older age groups show an increase.

II. AGE DISTRIBUTION OF WISCONSIN'S POPULATION COMPARED TO STANDARD MILLION DISTRIBUTION

Age Groups	Standard million Numbers	Standard million Per Cent	Real population Numbers	Real population Per Cent
Under 5	335,046	11.4	271,360	9.2
5– 9	314,473	10.7	291,222	9.9
10–14	302,717	10.3	286,477	9.7
15–19	293,901	10.0	271,427	9.2
20–24	282,144	9.6	244,104	8.3
25–34	476,119	16.2	442,619	15.1
35–44	361,497	12.3	412,661	14.0
45–54	261,572	8.9	311,745	10.6
55–64	176,343	6.0	213,696	7.3
65–74	96,987	3.3	137,125	4.7
75–up	38,207	1.3	56,570	2.0
Total	2,939,006	100.0	2,939,006	100.0

The following table (III) gives an analysis of the age distribution of the United States as a whole, the states of Wisconsin and Minnesota and the cities of Milwaukee, Minneapolis and Buffalo. Minnesota is comparable to Wisconsin both as to population and its urban, rural and occupational distribution. Minneapolis and Buffalo are comparable to Milwaukee for size and occupational distribution.

III. PERCENTAGE DISTRIBUTION OF POPULATION BY AGE GROUPS

1910, 1920 and 1930

Age Groups	United States 1910	United States 1920	United States 1930	Wisconsin 1910	Wisconsin 1920	Wisconsin 1930	Minnesota 1910	Minnesota 1920	Minnesota 1930
Under 5	11.6	10.9	9.3	11.0	10.8	9.2	10.9	11.0	9.0
5– 9	10.6	10.8	10.3	10.6	10.5	9.9	10.6	10.4	10.0
10–14	9.9	10.1	9.8	10.5	9.9	9.7	10.3	9.8	9.9
15–19	9.9	8.9	9.4	10.4	9.0	9.2	10.4	9.2	9.4
20–24	9.8	8.8	8.9	9.5	8.7	8.3	10.4	9.1	8.4
25–29	8.9	8.6	8.0	8.5	9.3	7.7	9.0	8.9	7.5
30–34	7.6	7.6	7.4	7.0	7.6	7.4	7.4	8.0	7.4
35–44	12.7	13.4	14.0	12.1	12.8	14.0	12.1	12.8	14.3
45–54	9.1	10.0	10.6	9.7	9.7	10.6	9.3	9.5	10.5
55–64	5.5	6.2	6.8	5.8	7.0	7.3	5.1	6.6	7.2
65–74	3.0	3.3	3.8	3.4	3.7	4.7	2.8	3.2	4.6
75–up	1.1	1.3	1.6	1.7	1.7	1.9	1.3	1.4	1.8
Unknown	0.2	0.1	0.1	0.1	0.1	0.1	0.2	0.1	--
Per Cent 30 years and above	39.2	41.9	44.3	39.8	42.6	46.0	38.2	41.6	45.8

Age Groups	Milwaukee 1920	Milwaukee 1930	Minneapolis 1920	Minneapolis 1930	Buffalo 1920	Buffalo 1930
Under 5	10.0	8.2	9.3	7.3	10.3	8.3
5– 9	9.4	8.3	8.1	8.3	9.4	9.1
10–14	8.3	8.2	7.2	7.7	8.4	9.0
15–19	8.1	8.7	7.4	7.9	7.9	8.7
20–24	9.8	9.8	10.1	9.3	9.2	8.7
25–29	10.3	9.6	11.2	8.8	10.1	8.5
30–34	9.3	8.8	10.1	8.8	9.1	8.5
35–44	14.4	15.8	15.0	17.2	14.5	16.2
45–54	9.8	10.6	10.2	11.4	10.7	11.1
55–64	6.3	6.4	6.7	7.1	6.6	7.0
65–74	2.8	3.6	2.8	4.3	2.8	3.7
75–up	1.0	1.2	0.8	1.5	1.0	1.1
Unknown	0.1	--	0.1	--	0.1	0.1
Per Cent 30 years and above	43.7	46.4	45.7	50.3	44.8	47.7

CANCER STATISTICS

Cancer Deaths

Since 1927 cancer has occupied second place as a cause of death in the registration area of the United States. It is surpassed only by heart disease. The following table, taken from the Bureau of the Census, shows the number of deaths in the United States in 1929 due to the seven leading causes of death:

PRINCIPAL CAUSES OF DEATH IN UNITED STATES REGISTRATION AREA FOR 1929

	Number of deaths
Heart disease	245,237
Cancer	111,569
Pneumonia (all forms)	106,597
Acute and chronic nephritis	106,056
Cerebral hemorrhage and softening	100,061
Tuberculosis (all forms)	88,352
Automobile accidents	29,531

The number of deaths from cancer is increasing throughout the registration area of the United States and also the percentage of all deaths in this area represented by cancer is increasing as shown by the following table:

IV. TABLE OF CANCER DEATHS IN REGISTRATION AREA AND PERCENTAGES OF ALL DEATHS REPRESENTED BY CANCER

1920–1929

Year	Number of cancer deaths	Percentage of all deaths
1920	71,756	6.4
1921	75,113	7.4
1922	78,355	7.5
1923	81,505	7.3
1924	85,241	7.9
1925	88,623	8.0
1926	92,500	7.9
1927	95,103	8.6
1928	99,000	8.3
1929	111,562	8.0

The above figures indicate a slight regression in the number of cancer deaths compared with all deaths, but it is too slight to have any special significance at this time.

Heart disease and cancer are the two diseases that are showing the most alarming increase in death rate throughout the United States. There is a slight increase in the death rate for nephritis while there is a marked decrease in the rate for pneumonia and tuberculosis. Table V gives these rates for the registration area of the United States for the decade 1920–1929.

In keeping with experience in other states and other countries, the number of cancer deaths in Wisconsin shows a marked annual increase, much greater than the increase either in the population as a whole or in that portion of the population in the cancer age period, age thirty and above. In 1910 the cancer death rate in Wisconsin was 65.9 per 100,000 population, in 1920 it was 88.4 per 100,000, and in 1930 it was 114.7 per 100,000. Since 1910 there has been an increase in the population of 25.9 per cent. During this same period there was an increase of 15.5 per cent in the population thirty years of age and over, and an increase in deaths from cancer of 119 per cent. The increase in the cancer death rate during these two decades has been 75.6 per cent. It is thus seen that the

V. DEATH RATE FOR CANCER AND OTHER LEADING CAUSES OF DEATH PER 100,000 POPULATION

1920–1929

UNITED STATES REGISTRATION AREA 1920

	1920	1921	1922	1923	1924	1925	1926	1927	1928	1929
Heart disease	159.3	157.1	165.7	175.3	178.1	185.5	199.1	195.7	208.3	210.9
Cancer	83.4	86.0	86.8	89.4	91.9	92.6	94.9	95.6	96.1	96.0
Pneumonia (all forms)	137.0	88.2	102.1	109.0	98.2	93.5	102.5	80.6	98.2	91.7
Nephritis	89.4	85.4	88.5	90.1	89.6	96.4	98.3	92.4	95.3	91.2
Cerebral hemorrhage and softening	86.0	83.6	86.0	90.5	92.7	84.4	86.3	84.0	87.2	86.1
Tuberculosis (all forms)	114.2	99.4	97.0	93.5	90.4	86.6	87.1	80.8	79.4	76.0

cancer death rate increased more than three times as much as did the population in the period 1910–1930, and nearly five times as much as did that portion of the population, age thirty and above, during this same period.

The cancer death rate for Milwaukee for 1910 was 68 per 100,000, for 1920 it was 80 per 100,000, and for 1930 it was 110 per 100,000. The following table shows these death rates in comparison with those for the United States Registration area:

VI. CANCER DEATH RATES IN THE U. S. REGISTRATION AREA—WISCONSIN AND MILWAUKEE

1910–1930

Year	U. S. registration area	Wisconsin	Milwaukee
1910	76.2	65.9	68.0
1915	81.4	74.8	82.0
1920	83.4	88.4	80.0
1925	92.6	105.6	90.7
1926	94.9	109.0	95.8
1927	95.6	107.3	104.0
1928	96.1	112.0	103.0
1929	95.9	111.9	101.0
1930	*	114.7	110.0

* Not yet available.

The rates noted in the preceding table are crude rates. Adjusted rates show but slight change and for the purposes of this survey are not so significant as are the crude rates which show a more accurate picture of the number of cancer cases treated in the community. Even though some of these cases may reside outside of Wisconsin, the professional and hospital facilities of the state are called upon for treatment and they properly form a part of the load carried by the cancer treatment facilities of the state. The cases coming from outside the state are probably offset by those cases which go to hospitals outside of Wisconsin for treatment so that the death rates are nearly equalized in practically all communities.

Since 1910 in Wisconsin the percentage of total deaths represented by cancer has doubled. While this may be explained, at least partially, by the marked reduction in deaths from communicable and epidemic diseases, it emphasizes the fact that the increase in the number of cancer deaths is very much greater than either the increase in the total population or in that portion of the population in the cancer age period, thirty years and over. Table VII illustrates this increase for the period 1910–1930 inclusive for both Wisconsin and Milwaukee.

When the percentage of cancer deaths in the group age thirty and above is determined for all deaths age thirty and above, this fact is again brought out over a period of years. In 1910 in Wisconsin the percentage of cancer deaths to total deaths age thirty and above was 10.4. In 1920 this had risen to 11.9, and in 1930 this percentage had increased to 14.1. Similar evidence is furnished from the records of the State Board of Health in which have been calculated the percentage deaths from cancer for persons 40 years of age and over to total deaths forty years of age and over 1907 to 1928 inclusive.

GOLF

See page 660 for the golf tournament plans at the September annual meeting.

VII. TOTAL DEATHS AND CANCER DEATHS IN WISCONSIN AND MILWAUKEE AND PERCENTAGE OF ALL DEATHS REPRESENTED BY CANCER

1910–1930

	Wisconsin			Milwaukee		
Year	Total deaths	Cancer deaths	Percentage of all deaths represented by cancer	Total deaths	Cancer deaths	Percentage of all deaths represented by cancer
1910	28,213	1,539	5.4	5,199	254	4.9
1915	26,676	1,838	6.8	4,886	336	6.8
1920	29,859	2,325	7.8	5,395	382	7.1
1921	27,674	2,605	9.4	4,568	388	8.5
1922	27,440	2,512	9.1	4,676	382	8.1
1923	29,336	2,534	8.6	5,200	400	7.7
1924	28,205	2,777	9.8	4,809	481	10.0
1925	29,380	2,942	10.0	5,537	472	8.5
1926	30,232	3,069	10.1	5,646	508	9.0
1927	29,665	3,053	10.2	5,725	572	10.0
1928	31,774	3,223	10.1	6,115	578	9.4
1929	31,284	3,252	10.4	6,107	591	9.7
1930	30,488	3,371	11.0	5,560	639	11.5

VIII. PERCENTAGE OF ALL DEATHS, AGE 40 AND OVER REPRESENTED BY DEATHS FROM CANCER, AGE 40 AND OVER

Year	Percentage	Year	Percentage
1907	8.6	1918	11.6
1908	10.0	1919	13.4
1909	11.0	1920	13.2
1910	11.2	1921	14.8
1911	11.0	1922	13.8
1912	11.4	1923	12.6
1913	11.4	1924	14.0
1914	12.0	1925	14.4
1915	11.6	1926	14.3
1916	11.4	1927	14.2
1917	11.4	1928	13.8

These statistics would indicate an actual increase in the incidence of cancer independent of the increasing percentage of the population now found in the cancer age groups and of other factors which may influence the situation. The actual increase in cancer was noted by the Bureau of the Census in its report on Mortality Statistics for 1930. On page 80 of that report it is stated that

> "The contention that cancer is not actually, but only apparently, increasing seems no longer tenable. Better diagnoses undoubtedly account for part of the increase shown but not for all of it. Figures for England and Wales, compiled by Dr. T. H. C. Stevenson, and published by the Registrar-General's report for 1917, clearly established an actual increase in mortality from cancer of accessible sites and our own figures presented in 1920 Mortality Statistics confirmed Dr. Stevenson's findings. For example, for females in the registration states of 1900, the 1900 adjusted death rate from cancer of the breast per 100,000 population female was 9.2 and the 1920 adjusted rate was 16.9, an increase of 84 per cent. For a site so accessible, it is inconceivable that the difference in the above rates could possibly be due to difference in diagnostic power."

The distribution of cancer deaths in Wisconsin by site of lesion and by age groups presents nothing of a striking or unusual character when compared with a similar analysis from other communities. The following table of cancer deaths by age and site of lesion for Wisconsin, 1930, has been formulated on the classification adopted by the United States Bureau of the Census in that year:

A table similar to the preceding one of cancer deaths in Milwaukee for 1930 has been formulated on the classification used by the United States Bureau of the Census previous to 1930. Likewise it shows no unusual deviation from similar statistics for other regions.

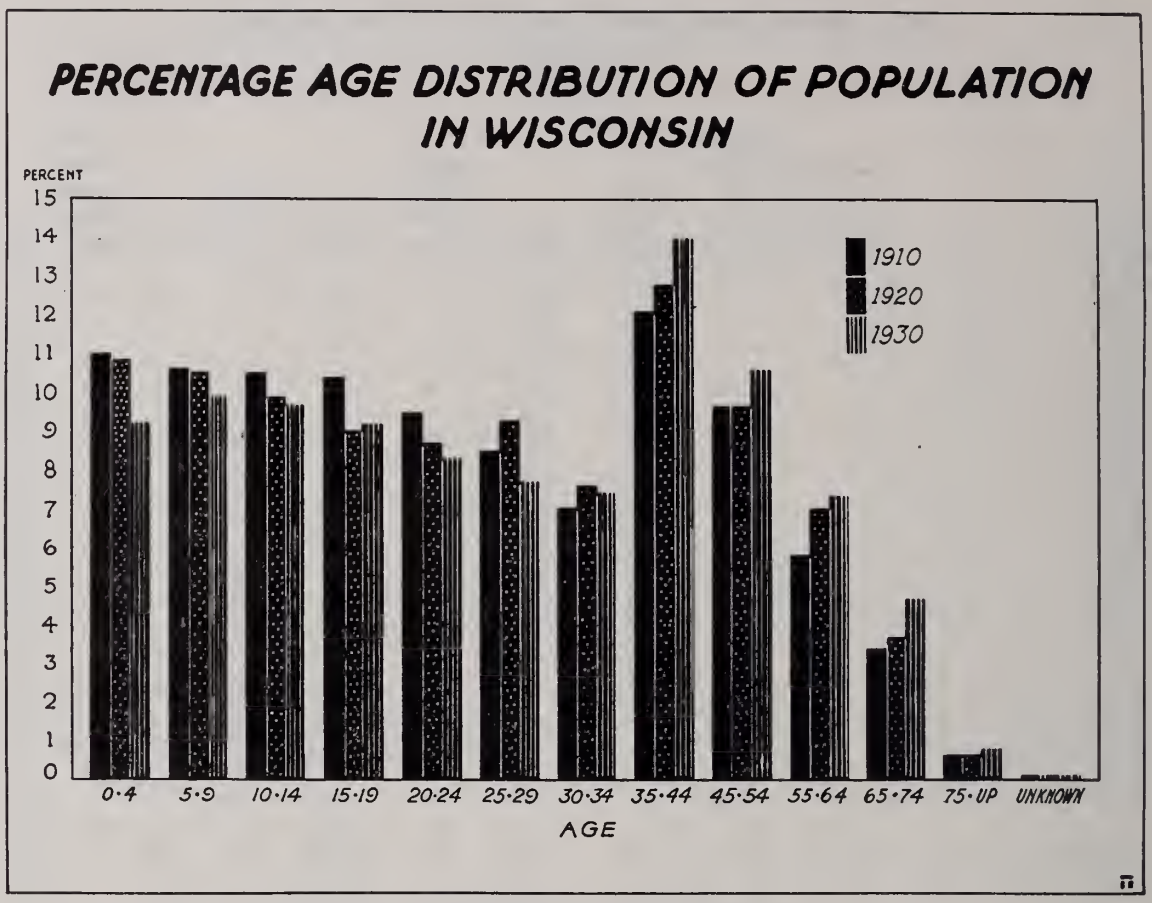
Plan now to attend the ninety-first annual meeting at Milwaukee, September 13th to 16th.

IX. CANCER DEATHS BY AGE AND SITE OF LESION
WISCONSIN
1930

Age groups	Buccal cavity and pharynx	Digestive tract and peritoneum	Respiratory system	Uterus	Other female genital organs	Breast	Male G. U. organs	Skin	Not otherwise classified	Total
Under 5	1	5	--	--	--	--	--	--	5	11
5– 9	--	2	--	--	--	1	--	--	3	6
10–14	--	--	2	2	--	--	1	--	3	8
15–19	1	1	1	--	2	--	1	--	4	10
20–24	2	4	--	3	1	--	1	--	4	15
25–29	1	7	1	5	2	2	1	--	4	23
30–34	2	11	1	10	2	2	3	2	5	38
35–39	5	30	3	14	3	15	2	--	9	81
40–44	2	54	1	20	5	29	5	--	11	127
45–49	7	84	10	19	8	27	12	2	18	187
50–54	7	156	13	34	8	34	14	5	18	289
55–59	11	200	16	35	8	38	19	5	31	363
60–64	13	251	8	35	5	32	37	6	29	416
65–69	20	353	17	30	4	32	55	7	33	551
70–74	21	353	12	20	3	22	52	10	25	518
75–79	21	246	5	14	4	18	40	13	27	388
80–84	8	134	1	5	3	14	34	9	10	218
85–89	6	50	--	1	1	6	13	7	5	89
90–94	2	16	--	1	--	3	1	6	1	30
95–up	--	1	--	1	--	--	1	--	--	3
Total	130	1,958	91	249	59	275	292	72	245	3,371

X. CANCER DEATHS BY AGE AND SITE OF LESION
MILWAUKEE, WISCONSIN
1930

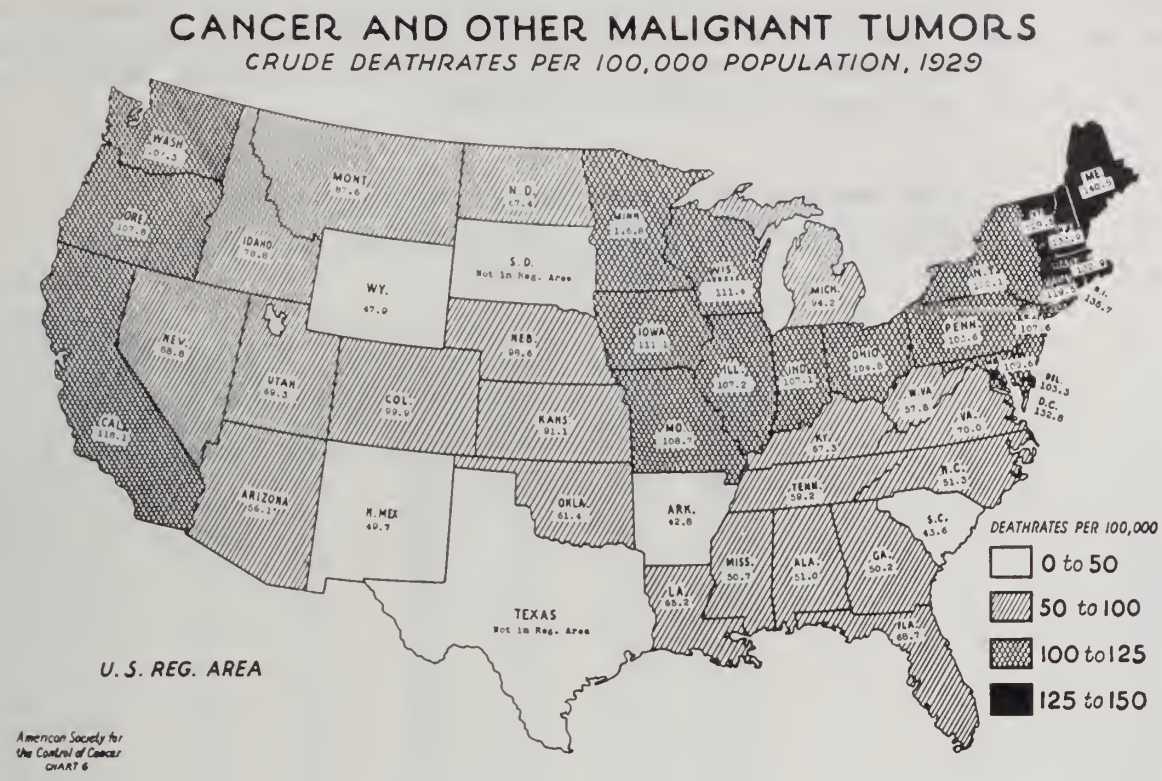
Age Groups	Buccal Cavity	Stomach Liver	Peritoneum Intestines Rectum	Female Genitals	Breast	Skin	Not Otherwise Classified	Total
Under 5	--	--	--	--	--	1	1	2
5– 9	--	--	--	--	--	--	--	--
10–14	--	--	--	--	--	--	2	2
15–19	--	--	--	--	--	--	1	1
20–24	--	--	--	1	--	--	1	2
25–29	--	--	2	--	1	--	1	4
30–34	--	--	--	5	--	1	3	9
35–39	1	3	2	3	3	1	6	19
40–44	1	7	7	6	8	2	3	34
45–49	1	16	8	3	6	1	5	40
50–54	1	24	3	15	11	2	10	66
55–59	1	26	12	10	9	1	17	76
60–64	3	41	8	12	7	3	13	87
65–69	3	47	15	9	5	1	25	105
70–74	4	50	6	6	5	--	16	87
75–79	2	26	12	4	3	1	9	57
80–84	--	15	5	--	3	1	9	33
85–89	1	4	2	1	1	--	2	11
90–94	--	2	--	--	1	--	1	4
95–up	--	--	--	--	--	--	--	--
Total	18	262	82	75	63	14	125	639



An analysis of the mortality statistics of the Wisconsin State Board of Health for 1930 shows that cancer as a cause of death was exceeded only by heart disease. From the following table it is seen that cancer killed more people in Wisconsin in 1930 than did tuberculosis, influenza, measles, scarlet fever, typhoid fever, smallpox, diphtheria, whooping cough, poliomyelitis, erysipelas, syphilis, lethargic encephalitis, epidemic meningitis, rheumatism and diseases of the thyroid combined. Accidents caused more than 1,000 fewer deaths than did cancer. Measured in relation to the passing of time, there was a death from cancer in Wisconsin every 2.5 hours during 1930.

Disease	Number of Deaths
Heart Disease	6,081
Nephritis	1,938
Tuberculosis	1,514
Accidents	2,319
Cancer	3,371
Influenza	472
Measles	99
Scarlet Fever	89
Typhoid Fever	25
Smallpox	4
Diphtheria	72
Whooping Cough	100
Poliomyelitis	28
Erysipelas	78
Syphilis	265
Lethargic encephalitis	32
Epidemic meningitis	65
Rheumatism	111
Diseases of thyroid	259
	1,699
Tuberculosis	1,514
Total	3,213

The major activities of the official health departments are directed toward the prevention and control of those diseases listed in the preceding table whose combined mortality is less than that of cancer. The occurrence of a comparatively few cases of any of these diseases at once sets into motion all the power and authority of the health departments for their control. On the other hand,



no official cognizance is taken of the presence of cancer, one of the most lethal of all diseases, and no portion of the budget of the state or any health department in Wisconsin is directed specifically toward its prevention and control. This statement is not made in criticism of such activities as are effectively directed toward the control of the common epidemic diseases, which would cause much suffering and some loss of life if they assumed epidemic proportions, but rather to emphasize the importance of cancer as a lethal disease and as a severe drain upon the social and economic life of the community.

Many diseases, as measles, diphtheria, scarlet fever, whooping cough and poliomyelitis, claim a large number of their victims during the years of childhood, and so measures for their prevention and control carry a weighty sentimental appeal to the general public. Cancer, striking at those in full maturity, and often past middle life, does not create so impressive a picture. The measures so far developed for controlling the disease are not equal in any degree to those found effective against the common communicable diseases. Nevertheless, there should be some sentimental appeal to the public on behalf of adult sufferers from cancer in addition to the weighty economic problems involved. Cancer too often strikes at the most productive period of life, when physical and mental efficiency are at their peak. The economic losses due to this disease are enormous, and the loss of capable and trained brained power is beyond measure.

County Distribution

In the last analysis the prevention and control of cancer must devolve in a large measure upon the community in which the cancer patient lives. Should the time come when the state and local governments take an active part in this work, it would be necessary to have available to local communities fairly definite information on the problem. The following table shows some of the important facts about cancer in Wisconsin distributed through the counties. The percentage of the population thirty years of age and over, the cancer death rate per 100,000, the number of licensed physicians and the ratio of phy-

sicians to population, have been calculated for each county. The number of living cancer cases has been estimated at three for each death and as the number of deaths approximates the number of licensed physicians in the state, this calculation also gives an average of three cancer patients per physician.

XI. POPULATION, CANCER DEATHS AND DEATH RATES

NUMBER LICENSED PHYSICIANS, AND RATIO TO POPULATION WISCONSIN, 1930

County	Population 1930	Per Cent population 30 and over	Number cancer deaths 1930	Death rate per 100,000	Number living cases*	Number licensed physicians	Cancer cases per physicians	Ratio physicians to population
Adams	8,003	40.8	10	125.0	30	3	10	2,668
Ashland	21,054	44.5	27	129.0	81	21	4	1,000
Barron	34,301	42.9	29	84.5	87	25	3	1,372
Bayfield	15,006	44.1	7	46.6	21	8	3	1,875
Brown	70,249	42.7	93	132.4	279	66	4	1,065
Buffalo	15,330	44.2	13	85.0	39	9	4	1,703
Burnett	10,233	45.7	12	117.6	36	6	6	1,705
Calumet	16,848	44.8	16	95.0	48	12	4	1,404
Chippewa	37,342	42.4	40	107.2	120	31	4	1,200
Clark	34,165	43.5	37	108.5	111	20	6	1,708
Columbia	30,503	51.3	43	141.0	129	37	3	824
Crawford	16,781	43.7	17	101.8	51	14	4	1,200
Dane	112,737	47.6	191	169.4	573	249	2	454
Dodge	52,092	48.8	55	105.8	165	32	5	1,628
Door	18,182	43.6	15	82.8	45	11	4	1,653
Douglas	46,583	46.8	58	124.7	174	37	5	1,259
Dunn	27,037	44.8	18	66.2	54	16	3	1,700
Eau Claire	41,087	46.0	64	156.1	192	41	5	1,000
Florence	3,768	45.8	2	53.1	6	2	3	1,884
Fond du Lac	59,883	48.6	108	180.6	324	74	4	809
Forest	11,118	38.5	4	36.0	12	7	2	1,588
Grant	38,469	48.7	51	132.8	153	36	4	1,070
Green	21,870	50.0	18	82.5	54	22	2	994
Green Lake	13,913	50.1	12	86.3	36	12	3	1,160
Iowa	20,039	48.2	35	175.0	105	17	6	1,180
Iron	9,933	42.3	2	20.2	6	5	1	1,986
Jackson	16,468	45.5	9	54.8	27	8	3	2,058
Jefferson	36,785	52.6	61	166.2	183	43	4	855
Juneau	17,264	48.1	36	208.3	108	13	8	1,328
Kenosha	63,277	44.1	42	66.4	126	57	2	1,110
Kewaunee	16,037	44.3	13	81.2	39	10	4	1,604
LaCrosse	54,455	47.2	92	169.1	276	55	5	990
Lafayette	18,649	47.0	13	70.0	39	20	2	932
Langlade	21,544	41.6	23	106.9	69	15	5	1,436
Lincoln	21,072	44.1	25	119.0	75	16	5	1,317
Manitowoc	58,678	43.5	57	97.2	171	41	4	1,431
Marathon	70,629	40.6	67	94.9	201	46	5	1,535
Marinette	33,530	43.3	25	74.6	75	23	3	1,458
Marquette	9,388	50.4	14	150.5	42	9	5	1,043
Milwaukee	725,263	46.5	858	118.3	2,574	1,006	3	721
Monroe	28,739	45.0	27	94.0	81	24	3	1,197
Oconto	26,386	41.2	22	83.6	66	14	5	1,885
Oneida	15,899	43.8	10	62.8	30	12	3	1,325
Outagamie	62,790	43.0	72	114.8	216	54	4	1,163
Ozaukee	17,394	47.3	22	127.1	66	12	5	1,450

XI. POPULATION, CANCER DEATHS AND DEATH RATES

NUMBER LICENSED PHYSICIANS, AND RATIO TO POPULATION WISCONSIN, 1930—Continued

County	Population 1930	Per Cent population 30 and over	Number cancer deaths 1930	Death rate per 100,000	Number living cases*	Number licensed physicians	Cancer cases per physicians	Ratio physicians to population
Pepin	7,450	45.3	6	80.5	18	5	4	1,490
Pierce	21,043	48.3	34	162.0	102	20	5	1,152
Polk	26,567	43.9	26	98.1	78	16	5	1,660
Portage	33,827	40.1	25	73.9	75	29	3	1,166
Price	17,284	41.7	10	58.1	80	8	10	2,160
Racine	90,217	46.2	112	124.1	336	81	4	1,113
Richland	19,525	44.1	20	102.5	60	16	4	1,220
Rock	74,206	48.8	107	144.2	321	99	3	750
Rusk	16,081	41.1	9	56.2	27	8	3	2,010
St. Croix	25,455	46.5	28	110.2	84	21	4	1,212
Sauk	32,030	49.2	45	140.6	135	30	4	1,068
Sawyer	8,878	43.2	5	56.8	15	4	4	2,220
Shawano	33,516	42.6	31	92.5	93	16	6	2,098
Sheboygan	71,235	46.3	79	110.9	237	67	4	1,063
Taylor	17,685	40.1	12	68.1	36	6	6	2,947
Trempealeau	23,910	45.5	25	104.6	75	22	3	1,087
Vernon	28,537	44.2	21	73.7	63	24	3	1,189
Vilas	7,294	43.1	4	54.8	12	5	2	1,459
Walworth	31,058	53.2	31	100.0	93	40	2	776
Washburn	11,103	42.8	3	27.0	9	7	1	1,586
Washington	26,551	47.5	30	113.2	90	21	4	1,264
Waukesha	52,358	48.3	65	124.4	195	67	3	781
Waupaca	33,513	47.5	43	128.3	129	35	4	957
Waushara	14,427	47.9	12	83.3	36	5	7	2,885
Winnebago	76,622	47.9	88	114.8	264	69	4	1,110
Wood	37,865	42.5	35	92.6	105	32	3	1,183
Total	2,939,006	46.0	3,371	114.7	10,113	3,028	3	970

* Estimated as three for each death.

A study of this table brings out some marked differences among which are those of the death rate per 100,000 population which varies from 20.2 in Iron County to 208.3 in Juneau County. The counties with the highest percentage of population, age 30 and over, do not always show the highest death rate from cancer. Neither does the density of population nor the ratio of physicians to population reveal any influence upon the number of deaths or the death rate. This table might well serve as the basis for further study by the component units of the State Medical Society in order to see if some correlation could be shown between the various items.

Hospital Cancer Cases

Forty-nine hospitals in Wisconsin with a bed capacity of 6,334 have reported in this survey. Of these hospitals, 33 were of 100 beds, or more, capacity. They were distributed through 24 counties of the state and with the exception of three institutions which reported a small number of cancer patients, all were visited and inspected by the field worker conducting the survey.

The total number of adult patients admitted to these hospitals in 1930 was 122,807. The cancer cases treated in these hospitals during the same year numbered 2,416, or 1.9 per cent, of the total admissions. The largest percentage of cancer patients in any hos-

XII. BED CAPACITY, PATIENTS, DEATHS AND AUTOPSIES IN CERTAIN WISCONSIN HOSPITALS IN 1930

Hospital	City	Bed capacity		Patients 1930			Deaths 1930				Autopsies 1930			
		Total	Cancer	Total	Cancer	Per cent cancer	Total	Per cent all admissions	Cancer	Per cent cancer admissions	Total	Per cent of all deaths	Cancer	Per cent cancer deaths
St. Elizabeth's	Appleton	200	n.s.	3,527	49	1.4	165	4.6	12	25.0	37	20.0	3	25.0
St. Joseph's	Ashland	130	n.s.	2,045	44	2.1	100	5.0	9	20.0	15	15.0	3	33.3
Beloit Municipal	Beloit	100	n.s.	1,340	14	1.0	107	8.0	5	35.0	26	24.3	4	80.0
*St. Joseph's	Chippewa Falls	185	n.s.	2,611	34	1.3	143	5.5	6	17.6	6	4.2	00	0.0
St. Joseph's	Dodgeville	50	n.s.	1,110	30	2.7	25	2.3	10	33.3	5	20.0	3	30.0
Luther	Eau Claire	147	n.s.	3,373	45	1.3	104	3.1	13	29.0	33	31.7	7	54.0
*Sacred Heart	Eau Claire	209	n.s.	4,102	57	1.3	134	3.2	13	23.0	35	26.0	4	31.0
St. Agnes	Fond du Lac	225	n.s.	3,663	133	3.6	166	4.5	36	27.0	80	48.2	15	41.6
Bellin Memorial	Green Bay	92	n.s.	1,626	26	1.6	70	4.3	2	7.7	00	....	00	....
St. Mary's	Green Bay	103	n.s.	3,287	31	.9	80	2.4	5	16.0	2	2.5	00	....
*St. Joseph's	Hartford	52	n.s.	726	4	.55	32	4.4	4	100.0	3	9.4	00	....
Mercy	Janesville	150	n.s.	2,026	36	1.7	97	4.7	10	27.7	30	31.0	3	30.0
Kenosha	Kenosha	150	n.s.	1,852	22	1.2	100	5.4	2	9.0	3	3.0	00	....
St. Catherine	Kenosha	51	n.s.	1,481	14	.9	74	5.0	4	28.5	14	19.0	3	75.0
Grandview	La Crosse	106	n.s.	1,769	54	3.0	44	2.4	8	14.8	36	81.8	6	75.0
Lutheran	La Crosse	140	n.s.	3,116	89	2.8	128	4.1	17	19.0	45	35.1	13	76.4
Methodist	La Crosse	50	n.s.	1,185	15	1.26	22	1.85	3	20.0	3	13.6	00	....
St. Francis	La Crosse	275	n.s.	4,558	96	2.1	197	4.3	12	12.5	46	23.3	4	33.3
Madison General	Madison	157	n.s.	3,346	36	1.1	111	3.31	16	44.4	19	17.1	1	6.2
Methodist	Madison	110	n.s.	2,511	62	2.4	82	3.26	19	30.6	14	17.0	7	36.8
St. Mary's	Madison	160	n.s.	4,108	52	1.2	181	4.4	20	34.5	47	26.0	4	20.0
State of Wisconsin	Madison	575	n.s.	6,800	243	3.5	270	4.0	29	12.2	170	63.0	21	72.4
Holy Family	Manitowoc	125	n.s.	1,874	30	1.6	121	6.4	12	40.0	1	.8	00	....
M and M	Marinette	60	n.s.	1,126	16	1.4	48	4.26	1	6.2	10	20.8	1	100.0
St. Joseph's	Marshfield	150	n.s.	2,490	58	2.3	120	4.8	11	19.0	48	40.0	4	36.3
Holy Cross	Merrill	50	n.s.	597	20	3.3	39	6.5	00	....	00	....	00	....
Columbia	Milwaukee	100	n.s.	2,189	63	2.9	82	3.7	6	9.5	32	39.0	2	33.3
Evangelical Deaconess	Milwaukee	152	n.s.	4,155	48	1.25	145	3.5	13	27.0	33	22.7	2	14.3
Milwaukee	Milwaukee	215	n.s.	4,244	113	2.6	156	3.6	21	18.5	22	14.1	00	....
Milwaukee County	Milwaukee	1,000	n.s.	7,511	178	2.3	780	10.3	79	44.3	360	46.1	45	57.0
Milwaukee General	Milwaukee	200	n.s.	3,133	17	.54	86	2.7	4	23.5	17	20.0	00	....
Misericordia	Milwaukee	110	n.s.	2,644	48	1.8	81	3.0	11	23.0	11	13.5	3	27.2
Mt. Sinai	Milwaukee	140	n.s.	4,062	54	1.3	191	4.7	18	33.3	49	25.6	2	11.0
*Roger Williams	Milwaukee	40	n.s.	875	36	4.1	16	1.8	4	11.0	9	56.2	00	....
St. Joseph's	Milwaukee	350	n.s.	3,730	96	2.57	158	4.2	14	14.6	25	15.8	1	7.1
St. Luke's	Milwaukee	100	n.s.	1,597	24	1.5	89	5.5	7	29.0	4	4.5	00	....
Theda Clark Memorial	Neenah	55	n.s.	1,394	26	1.8	80	5.7	9	34.6	2	2.5	00	....
Summit	Oconomowoc	35	n.s.	500	20	4.0	16	3.2	5	25.0	8	50.0	00	....
Mercy	Oshkosh	95	n.s.	2,689	91	3.4	115	4.3	16	17.6	21	18.2	6	37.5
Prairie du Chien	Prairie du Chien	70	n.s.	1,050	26	2.4	26	2.4	7	27.0	4	15.4	3	42.8
St. Luke's	Racine	120	n.s.	2,422	34	1.4	99	4.0	10	30.0	13	13.0	4	40.0
St. Mary's	Racine	90	n.s.	2,443	47	1.9	111	4.5	15	31.9	43	38.7	4	26.6
St. Mary's	Rhinelander	65	n.s.	977	12	1.2	66	6.7	7	58.3	4	6.0	00	....
*St. Nicholas	Sheboygan	140	n.s.	2,669	46	1.7	136	5.1	7	15.2	2	1.5	1	14.3
St. Michaels	Stevens Point	90	n.s.	1,251	23	1.8	73	5.8	4	17.4	10	13.7	00	....
St. Mary's	Superior	100	n.s.	1,307	37	2.8	103	7.8	8	21.6	52	50.0	7	86.3
*St. Mary's	Watertown	50	n.s.	1,238	9	.72	38	3.0	1	11.1	2	8.0	00	....
St. Mary's	Wausau	120	n.s.	2,859	46	1.6	60	2.1	9	20.0	8	13.3	2	22.2
Wausau Memorial	Wausau	95	n.s.	1,619	12	.74	51	3.15	3	25.0	00	....	00	....
Total		6,334		122,807	2,416	1.9	5,518	3.68	557	12.2	458	32.2	188	33.7

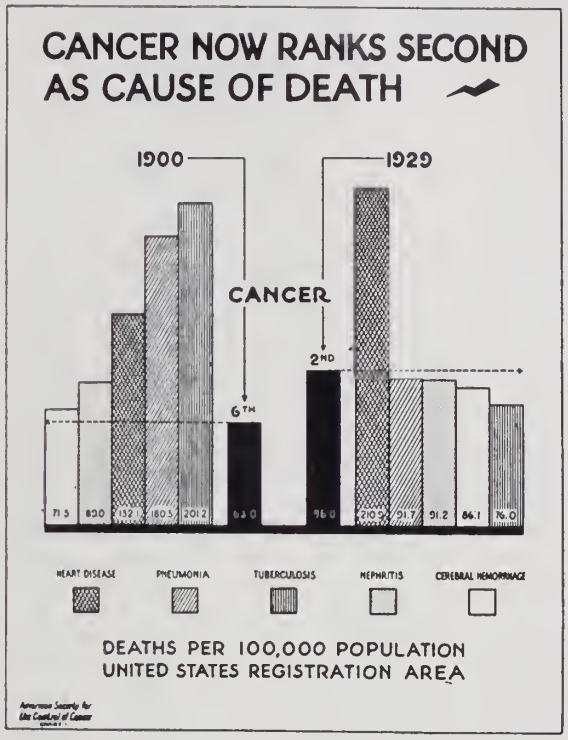
n.s. Not specified.
* Not approved by the American College of Surgeons.

pital was 4.1 and the lowest .54. It is thus seen that in the average general hospital of Wisconsin the number of cancer cases at any given time forms but a small percentage of the total adult admissions to the institutions. The small number of cancer patients, however, does not indicate their relative importance in the work of the hospital for the reason that, potentially at least, the treatment received by these patients determines to a large extent the death rate from this disease. The statement just made can and will become an actuality when cancer patients are seen sufficiently early in the disease for adequate treatment to play a large part in the recovery and the future health of the patient.

That cancer patients are being seen in the late stages of the disease in the majority of cases is emphasized by the high percentage of deaths in these cases compared to the deaths from all admissions. In the Wisconsin hospitals reporting, 23 per cent of the cancer patients died in the hospitals while the percentage of deaths from all admissions was but 3.68.

In the matter of autopsies a wide variation is shown among the hospitals. Some hospitals with a considerable number of admissions reported few or no autopsies performed during 1930 either on cancer or other patients. From the information gathered in this survey the conclusion seems warranted that where there was no pathologist on the staff, or other staff member interested in autopsy work, the number of autopsies performed was at a minimum; while in those institutions having either a full-time pathologist or staff member interested in pathological work, the number of autopsies showed a marked increase. Table XII gives the detailed information on the matter of admissions, deaths, and autopsies as reported by the different hospitals.

Assuming three living cases for each cancer death it is seen that not more than one-fourth of the cancer patients in the state in 1930 received hospital care and treatment. Of course cancer cases are seen in the smaller hospitals not included in this survey, but their total number is so small that it would not materially affect the total number



of hospitalized cancer patients noted previously.

To each of but four hospitals of the state there were 100 or more cancer patients admitted. This fact together with the small number of cancer patients in the average general hospital would indicate that in a centralized and well organized service for the diagnosis and treatment of these patients would rest the best opportunity for an attack on this problem.

The State of Wisconsin General Hospital at Madison reported the largest number of cancer admissions (243) of any hospital in the state for 1930. Other hospitals reporting 100 or more cancer patients were:

Milwaukee County	178
St. Agnes, Fond du Lac	133
Milwaukee, Milwaukee	113

Cancer patients in the State of Wisconsin General Hospital were received from the following counties, in the numbers indicated, the table also showing the percentage of living cases in each county treated in this hospital.

From the table it is seen that more than 56 per cent of the cancer cases seen in this hospital came from ten counties, which, with

XIII. COUNTY DISTRIBUTION OF CANCER CASES IN STATE OF WISCONSIN GENERAL HOSPITAL, 1930

County	Patients Received	Number Living Cases	Per Cent Treated
Adams	2	30	6.6
Ashland	2	81	2.4
Bayfield	1	21	5.0
Brown	1	279	0.35
Chippewa	2	120	1.6
Clark	1	111	0.9
Columbia	8	129	6.2
Crawford	1	51	2.0
Dane	33	573	5.7
Dodge	2	165	1.2
Douglas	1	174	0.57
Eau Claire	1	192	0.52
Fond du Lac	8	324	2.47
Grant	9	153	5.8
Green	9	54	16.6
Green Lake	2	36	5.5
Iowa	2	105	1.9
Jackson	1	27	3.7
Jefferson	20	183	10.9
Juneau	5	108	4.6
Kenosha	5	126	3.9
La Crosse	2	276	0.7
Lafayette	4	39	10.2
Langlade	1	69	1.4
Manitowoc	1	171	0.58
Marathon	4	201	2.0
Marinette	10	75	13.3
Marquette	1	42	2.38
Milwaukee	4	2,574	0.15
Oconto	3	66	4.5
Outagamie	2	216	0.9
Pierce	2	102	2.0
Portage	6	75	8.0
Price	2	80	2.5
Racine	4	336	1.2
Richland	1	60	1.6
Rock	25	325	7.7
Rusk	4	27	14.8
Sauk	7	135	5.2
Shawano	2	93	2.15
Sheboygan	1	237	0.42
St. Croix	2	84	2.38
Taylor	4	36	11.0
Trempealeau	3	75	4.0
Vilas	2	12	16.6
Vernon	3	63	4.7
Walworth	8	93	8.6
Waukesha	2	195	1.0
Waupaca	5	129	3.8
Waushara	2	36	5.5
Winnebago	2	264	0.76
Wood	6	105	5.7
Total	241*	9,333	2.5

* Two cases from Illinois were treated in this hospital in 1930.

two exceptions, are situated in the southern part of the state. The table also shows the percentage of the estimated number of cancer patients receiving treatment in this hospital. For those counties sending cancer patients to this hospital, only 2.5 per cent of the estimated number of living cancer patients were sent. Of the estimated total number of living cancer patients in the state but 2.3 per cent received treatment in the state hospital at Madison.

CANCER TREATMENT FACILITIES

Hospitals

There is no hospital in Wisconsin devoted exclusively to the treatment of cancer and allied diseases. All the general hospitals receive and treat cancer cases. Of the hospitals reporting in this survey, all but six are on the approved list of the American College of Surgeons as being adequately equipped for the work they are carrying on. Details of facilities in these hospitals are shown in table XIV.

X-ray Equipment

Six of the hospitals surveyed are equipped with deep therapy apparatus of a capacity of 200,000 volts or more, the voltage considered essential by the American College of Surgeons for acceptable cancer therapy. Other hospitals reported that the x-ray equipment, with the exception of the tubes, was constructed to carry 200,000 volts or more, but that the tubes in use carried a lower voltage.

As was to be expected, there was a wide difference of opinion among the radiologists and surgeons interviewed as to the optimum dosage of x-ray in cancer therapy. Some held that frequent repeated doses of from 75,000 to 125,000 volts was preferable to single or few treatments with a voltage of 200,000 or more. Certain other radiologists also stated that while their tubes could carry higher voltages, as a matter of economy and to prolong the life of the tubes, they were being used at less than their maximum capacity.

In some communities there was no deep therapy x-ray equipment in the hospital, but it was available in the offices of private physicians. In other hospitals without deep

XIV. CANCER TREATMENT FACILITIES IN CERTAIN WISCONSIN HOSPITALS

Hospital	City	Bed capacity		Deep therapy capacity in kv.	Milligrams owned	Radium rented	Radon used	Laboratory		Pathologist		Teaching affiliation	Outpatient department	Social service department	Organized follow up service**
		Total	Cancer					Tissue	Frozen sections	Physician	Full or part time				
St. Elizabeth	Appleton	200	n.s.	200	No	Yes	No	Yes	Yes	Yes	Part	No	No	No	No
St. Joseph's	Ashland	130	n.s.	135	No	Yes[1a]	No	Yes	Yes	Yes	Full	No	No	No	No
Beloit Municipal	Beloit	100	n.s.	165	No	Yes	No	Yes	Yes	Yes	Part	No	No	No	No
*St. Joseph's	Chippewa Falls	185	n.s.	No	No	No	No	No	No	No	None	No	No	No	No
St. Joseph's	Dodgeville	50	n.s.	No	No	Yes	No	No	No	No	None	No	No	No	No
Luther	Eau Claire	147	n.s.	No[1]	No	Yes[2]	No	Yes	Yes	Yes	Part[3]	No	No	No	No
*Sacred Heart	Eau Claire	209	n.s.	No[1]	No	Yes[2]	No	Yes	Yes	Yes	Part[3]	No	No	No	No
St. Agnes	Fond du Lac	225	n.s.	120	No	Yes[4]	No	Yes	Yes	Yes	Full	No	No	No	No
Bellin Memorial	Green Bay	92	n.s.	135	No	Yes[5]	No	No	No	No	None	No	No	No	No
St. Mary's	Green Bay	103	n.s.	No	No	Yes[5]	No	Yes	Yes	No	None	No	No	No	No
*St. Joseph's	Hartford	52	n.s.	No	No	Yes	No	No	No	No	None	No	No	No	No
Mercy	Janesville	150	n.s.	No	No	Yes	No	Yes	Yes	Yes	Part	No	No	No	No
Kenosha	Kenosha	150	n.s.	160	No	Yes	No	Yes	Yes	Yes	Part	No	No	No	No
St. Catherine	Kenosha	51	n.s.	145	No	Yes	No	Yes	Yes	Yes	Full	No	No	No	No
Grandview	La Crosse	106	n.s.	130	No	No	No	Yes	Yes	Yes	Part	No	No	No	No
Lutheran	La Crosse	140	n.s.	140	No	Yes[6]	No	Yes	Yes	Yes	Part	No	No	No	No
Methodist	La Crosse	50	n.s.	No	No	Yes	No	No	No	Yes	Part	No	No	No	No
St. Francis	La Crosse	275	n.s.	165	100	Yes	No	Yes	Yes	Yes	Full[7]	No	No	No	No
Madison General	Madison	157	n.s.	140	No	Yes	No	Yes	Yes	Yes	Full	No	No	Yes	No
Methodist	Madison	110	n.s.	110	No	Yes[8]	No	Yes	Yes	Yes	Part	No	No	No	No
St. Mary's	Madison	160	n.s.	150	No	Yes	No	Yes	Yes	Yes	Full	No	Yes	Yes	Yes
State of Wisconsin	Madison	575	n.s.	200	546	No	Yes	Yes	Yes	Yes	Full	Yes	Yes	Yes	No
Holy Family	Manitowoc	125	n.s.	165	No	Yes	No	Yes	Yes	No	None	No	No	No	No
M and M	Marinette	60	n.s.	No	No	Yes	No	No	No	Yes	Part	No	No	No	No
St. Joseph's	Marshfield	150	n.s.	140	No	Yes[9]	No	Yes	Yes	Yes	Part	No	No	No	No
Holy Cross	Merrill	50	n.s.	150	No	Yes	No	Yes	Yes	No	None	No	No	No	No
Columbia	Milwaukee	100	n.s.	155	No	Yes[10]	No	Yes	Yes	Yes	Part	No	No	No	No
Evangelical Deaconess	Milwaukee	152	n.s.	140	No	Yes	No	Yes	Yes	Yes	Part	No	No	No	No
Milwaukee	Milwaukee	215	n.s.	300	No	Yes	Yes	Yes	Yes	Yes	Full	No	No	No	No
Milwaukee County	Milwaukee	1,000	n.s.	150	No	Yes	No	Yes	Yes	Yes	Full	Yes	Yes	Yes	No
Milwaukee General	Milwaukee	200	n.s.	200	No	Yes	No	Yes	Yes	Yes	Part	Yes	No	Yes	No
Misericordia	Milwaukee	110	n.s.	No	No	Yes	No	Yes	Yes	Yes	Part	Yes	No	Yes	No
Mt. Sinai	Milwaukee	140	n.s.	No	No	Yes	No	Yes	Yes	Yes	Full	No	Yes	Yes	No
*Roger Williams	Milwaukee	40	n.s.	200	No	Yes	No	Yes	Yes	Yes	Part	No	No	Yes	No
St. Joseph's	Milwaukee	350	n.s.	140	No	Yes	No	Yes	Yes	Yes	Part	Yes	No	No	No
St. Luke's	Milwaukee	100	n.s.	No	No	Yes	No	Yes	Yes	Yes	Part	No	No	No	No
Theda Clark Memorial	Neenah	55	n.s.	No	No	No	No	Yes	Yes	Yes	Part	No	No	No[11]	No
Summit	Oconomowoc	35	n.s.	No	No	Yes	No	No	No	No	None	No	No	No	No
Mercy	Oshkosh	95	n.s.	160	No	Yes[12]	No	Yes	Yes	Yes	Part	No	No	No	No
Prairie du Chien	Prairie d'Chien	70	n.s.	No	No	Yes	No	No	Yes	Yes	Part	No	No	No	No
St. Luke's	Racine	120	n.s.	No	No	Yes	No	No	No	No	None	No	No	No	No
St. Mary's	Racine	90	n.s.	250	No	Yes	No	Yes	Yes	Yes	Part	No	No	No	No
St. Mary's	Rhinelander	65	n.s.	No	No	Yes	No	Yes	No	No	None	No	No	No	No
*St. Nicholas	Sheboygan	140	n.s.	No	No	Yes	No	No	Yes	No	None	No	No	No	No
St. Michaels	Stevens Point	90	n.s.	No	No	No	No	No	No	No	None	No	No	No	No
St. Mary's	Superior	100	n.s.	150	No	Yes[13]	No	Yes	Yes	Yes	Part	No	No	No	No
*St. Mary's	Watertown	50	n.s.	No	No	No	No	Yes	No	No	None	No	No	No	No
St. Mary's	Wausau	120	n.s.	120	No	Yes	No	Yes	Yes	No	None	No	No	No	No
Wausau Memorial	Wausau	95	n.s.	No	No	Yes	No	Yes	Yes	Yes	Part	No	No	No	No

n.s. Not specified.
* Not approved by the American College of Surgeons.
** Social worker devoting all or major portion of time to cancer work.
Notes:
[1] Deep therapy available in Eau Claire.
[1a] 75 milligrams of radium available in Ashland.
[2] 100 milligrams radium available through staff.
[3] Pathologist serves both Eau Claire hospitals.
[4] 225 milligrams radium available in Fond du Lac.
[5] 160 milligrams radium available in Green Bay.
[6] 100 milligrams radium available through staff.
[7] Full-time service began Dec. 1, 1931.
[8] 110 milligrams radium available through staff.
[9] 148 milligrams radium available through staff.
[10] 242.5 milligrams radium available through staff.
[11] V. N. A. does social service work.
[12] 50 milligrams radium available through staff.
[13] 100 milligrams radium available nearby in Duluth, Minn.

therapy, patients needing such treatment were referred to other institutions where such facilities were available with physicians in attendance who are trained in this form of therapy.

It may not be out of place to point out at this time the dangers arising from the use of this highly specialized form of therapy by physicians without adequate training in either the physics or therapeutics of its application. A powerful force, about which much remains to be known, is brought into play when deep therapy x-ray treatments are given. Not only should the operator be thoroughly familiar with the therapeutic and physiologic reaction of this force upon the human system, but his experience with the use of this form of therapy should have been sufficiently extensive to enable him to appreciate the differences in reaction that take place in different individuals. The use of such equipment as an additional source of revenue without a thorough knowledge of its physiological effects can not be defended on any grounds of medical science. Progress in cancer control can be made only through the scientific approach and not by the commercialized medical route. The welfare of the patient must be held paramount to all other considerations entering into his treatment, and the use of either x-ray or radium therapy for any other purposes does much to discredit the legitimate use of this form of therapy in the hands of capable physicians.

Radium

The largest single amount of radium found in Wisconsin was 546 milligrams in the State of Wisconsin General Hospital in Madison. At this hospital was also found the only radium emanation plant in the state. One other hospital, St. Francis in La Crosse, owns 100 milligrams of radium. Private physicians or clinic groups in the following cities report ownership of the indicated amount: Ashland 75 mg.; Eau Claire 100 mg.; Fond du Lac 225 mg.; Green Bay 160 mg.; La Crosse 100 mg.; Madison 110 mg.; Marshfield 148 mg.; Milwaukee 242.5 mg.; Oshkosh 50 mg.; for Superior and other communities in the northwestern part of the state, 100 mg. are available nearby in Duluth, Minnesota. This gives a total of 1856.50 mg. of radium owned in the state. There may be other small quantities of radium but it is believed they are not large.

The radon produced by the emanation plant at the state hospital in Madison is practically all used by that institution. Elsewhere in the state little radon is used.

It is the custom in many hospitals owning no radium for the members of the medical staffs of these hospitals to use rented radium when the occasion demands. This radium is obtained from Milwaukee, Chicago, Quincy, Ill., or New York in a large majority of cases.

As was found to be the case with the use of deep x-ray therapy, opinion among Wisconsin physicians differs regarding the use of radium in the treatment of cancer. Many surgeons are opposed to its use because of the unfortunate results that have been seen when it is used by physicians without adequate training in this form of therapy. Others express an opinion favorable to surgery or other form of therapy based largely on the fact that no radium is available locally nor have they themselves had training in its use. In general those members of the medical profession with whom the matter was discussed were aware of the types of cancer in which radium was indicated in preference to surgery.

Like deep x-ray therapy, the use of radium is one of the newest and most powerful agents known to medical science and the possibilities for harm connected with its use by physicians without training and experience are so great that its application to human patients should be surrounded with all the safeguards that medical science can suggest. Inasmuch as the objections raised to the use of radium are dependent largely on the poor results obtained in the hands of inexperienced users, failure by the general profession to use this agent is more to be commended than criticised. The proper use of radium and radon, as well as of deep therapy, requires a high degree of skill and training and a special knowledge of their effects on human tissues, and the welfare of the patient is better safeguarded by the use of acceptable surgical procedures than by

irradiation in the hands of untrained physicians.

Laboratory Facilities

Eight of the hospitals reporting in this survey were found to be without laboratory equipment for tissue work. Practically all of these hospitals send tissues to the State Laboratory of Hygiene at Madison or to other hospitals for examination. Six other hospitals were found with equipment for making tissue examinations, but were without the services of a pathologist. In the majority of these hospitals, a technician was in charge of the laboratory work.

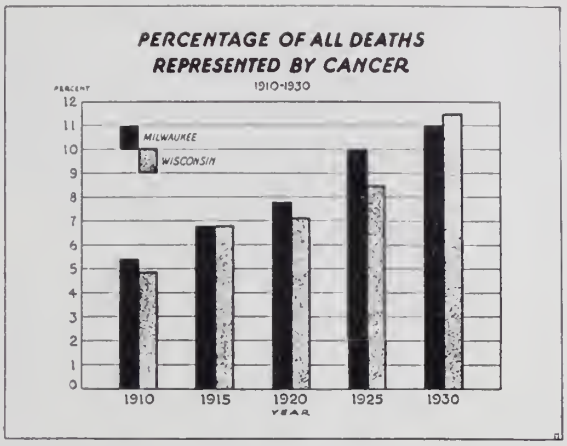
Pathologists devoting all or a major portion of their time to laboratory work were found in Superior, Ashland, Eau Claire, La Crosse, Marshfield, Appleton, Oshkosh, Fond du Lac, Madison, Milwaukee, and Kenosha. While it does not come within the scope of this report to evaluate the training and ability of pathologists to properly interpret cancer tissues by microscopic examination, it may be well to point out that special training and considerable experience are necessary to the proper interpretation of cancer tissue specimens. The decision as to whether a given tissue is or is not malignant often may be a difficult one and an extended experience in this field is a requisite to competency.

Out-Patient Service

But four hospitals were found with regularly organized out-patient departments. In the majority of communities it is reported that the medical profession has undertaken to care for indigent patients in their offices, thus obviating the necessity for the operation of regular out-patient departments in general hospitals.

Cancer Clinics

No organized cancer service or clinic was found in any Wisconsin hospital. In a number of hospitals the question of an organized service along the lines recommended by the American College of Surgeons was under consideration, and it is probable that such clinics will soon be organized in several hospitals throughout the state.



Social Service

Eight hospitals reporting in this survey maintain social service departments. In none of these, however, was there found a sustained follow-up system in regard to cancer patients. They were all concerned with a general social service program.

Research

At the time of this survey no active research work on cancer problems was found in any of the hospitals visited.

Teaching Affiliations

There are two medical schools in Wisconsin—the Medical Department of Marquette University at Milwaukee and the Medical school of the University of Wisconsin at Madison. Both are Class A schools, giving the full four years' course of undergraduate instruction.

The Marquette Medical School has concentrated its general hospital teaching in the Milwaukee County Hospital. Instruction in special subjects such as maternity, pediatrics, contagious diseases, tuberculosis, and neuro-psychiatry is given in special hospitals in Milwaukee. The hospital instruction in cancer for the students of this school has not been organized for presentation as a specialized subject. The instruction in diagnosis and treatment of cancer is presented in the general curriculum. Marquette University operates a radio broadcasting station and in the course of broadcasts by the medical school, cancer is discussed several times a year.

The Medical School of the University of

Wisconsin centers its undergraduate instruction in the State of Wisconsin General Hospital at Madison. There is no special organization for the diagnosis and treatment of cancer in this hospital and the students receive their training in cancer diagnosis and treatment in the same manner as that given for other diseases.

In addition to the training received in the State of Wisconsin General Hospital at Madison, senior students in this school are taught under the preceptor plan by being sent to various cities throughout the state where they spend a definite period in association with a physician in his regular medical practice. Because of the lack of organized cancer facilities in any of the hospitals in Wisconsin, there is no opportunity for these medical students to obtain special training or instruction in cancer diagnosis and therapy.

It is believed that one of the requisites for an improved program of cancer treatment is the better appreciation by the medical profession of the cancer problem and a better training in acceptable diagnostic and therapeutic procedures. While the number of patients suffering from cancer constitute but a small percentage of admissions to general hospitals, there is no disease that carries with it such a high mortality. For this reason, cancer assumes an importance that may seem out of all proportion to the number of patients suffering from it; but when it is realized that it is almost always fatal under present conditions, the necessity for a more extended and thorough knowledge of the disease is demanded from the medical profession.

One method of bringing about a better appreciation of the cancer problem by the medical profession is by giving undergraduate medical students the best possible training in the diagnosis and treatment of the disease. Such students should be made familiar with all diagnostic and therapeutic procedures used. They should understand biopsy technique, and preferably assist in such work. They should follow the tissue through the laboratory and study the microscopic sections. They should be familiar with the history of the case and keep in touch with the follow-up and observation of the patient after treatment. Inasmuch as all the above procedures are now accepted as desirable for adequate diagnosis and treatment of cancer patients, the medical student should have as thorough a training in them as possible.

In addition to participation in diagnosis and treatment, the undergraduate medical student should have an opportunity to become familiar with the social and economic problems involved. As many of the cancer patients treated in the State Hospital at Madison are residents of other communities of the state, it would seem the logical thing for the medical students who have studied these cases in the hospital to continue their observations in the homes of the patients when spending the required time under preceptor training. By this means a more complete picture of the cancer patient could be obtained than if the contact with him is limited to certain aspects of the hospital care of the patient.

An increasing amount of responsibility for cancer diagnosis and treatment will rest upon the physician of tomorrow, who is the medical student of today, and every effort should be made by those in charge of medical education to provide the most adequate training possible for these men and women.

Another necessary element in an improved service is the giving of postgraduate courses and the holding of staff conferences on cancer cases. In this way, physicians in active practice will have an opportunity to obtain the latest information on the subject which would in turn be translated into an improved service to the cancer patient. No other group is so well fitted to take the leading part in a program of cancer control as is the medical profession, but to merit and maintain this leadership, the profession must be alert to and take advantage of all opportunities for furthering the education of its members in this important field of medical practice. The hospital staff conference offers one of the best opportunities for postgraduate education, as all parties to the diagnosis and treatment of the case are available for consultation and discussion. The pathologist can present the evidence disclosed by the laboratory and the microscope, the radiolo-

gist can interpret the x-ray findings, and the diagnostician can contribute the results of his examination. From these combined reports the best treatment of the patient should be developed and all features of the case made available for study and discussion.

State Department of Health

The State Department of Health through the State Laboratory of Hygiene, provides a diagnostic service for the examination and interpretation of tumor tissue. In addition it issues educational material on cancer for the general public throughout the state. It cooperates with the State Medical Society in the preparation of educational releases for distribution to the newspapers of the state, and through the public addresses by the department personnel, cancer problems are discussed before various types of audiences. The department also collects and publishes statistical information on the number of cancer deaths and their distribution.

Extension Division

The Extension Division of the State University, in cooperation with the Medical Schools, contributes to postgraduate medical education by the organization of courses of ten to twelve weeks duration on special subjects to be given in different communities. By this means instruction is brought to the homes of the physicians in such a way as to make it unnecessary for them to leave their practice for extended periods for postgraduate work.

Short courses occupying one or two days only are given also in districts where enough physicians will register to make it worth while. These courses are of the lecture and demonstration type and include no actual work by the physician registering for them.

Medical institutes, usually of one or two weeks duration, are given at the State of Wisconsin General Hospital in Madison as another type of postgraduate instruction. These are intensive courses, mostly for specialists, and each institute is devoted to some special subject.

By the three methods just outlined, it is possible for a generous amount of postgraduate instruction to be given to the physicians of Wisconsin with very little effort or expense on their part.

A package medical library is maintained by the Extension Division whereby books, magazines, and reprints on medical subjects will be sent to any physician in the state so that the latest authentic information on any medical subject is available to all Wisconsin physicians.

Milwaukee Health Department

This department carries on no special cancer activities. Cancer cases are found occasionally in each of the four health centers maintained by the department, and the department visiting nurses, of whom there are eighty-five, frequently discover cancer patients in the course of their home visiting. Such cases are urged to seek competent medical advice.

The Health Commissioner urges all department employees to have an annual physical examination. For this purpose, each employee is permitted a day off with pay during the year and is required to bring a certificate from the physician who examined him certifying that the examination has been made and that particular "attention to heart, lungs, blood pressure, urinalysis, and any signs or symptoms of cancer" has been given. The monthly bulletin of the department also carries occasional informative articles on the subject of cancer.

State Medical Society

The State Medical Society in cooperation with the State Department of Health issues weekly educational releases to the newspapers of the state on health and medical subjects. The question of cancer is one of the subjects discussed in these releases. The medical society also has a cancer committee whose interest in the present survey is recorded in the official report of the Council Meeting on pages 2, 3, and 4 of this report.

Other Organizations

It is believed that the foregoing recital of activities of various organizations and institutions practically covers the active organized interest in cancer in Wisconsin. In addition should be mentioned the work of the

Wisconsin Anti-Tuberculosis Association which gives courses in public health nursing to groups of nurses during which two or three lectures are devoted to the subject of cancer. The Visiting Nurse Associations of various cities are called upon to care for cancer patients in the course of their regular work.

Practically all health and welfare organizations encounter cancer at some time in their work. The part cancer plays in the charitable needs of a community has never been calculated, but it is realized that it is of much greater importance than has been considered in the past. While the aggregate number of families involved may not be large, the disorganization caused by the presence of the disease in the individual family may be crushing and require prolonged assistance from the philanthropic resources of the community. The State Medical Society might well include a study of the economic aspects of cancer in its program of activities.

CANCER PREVENTION AND CONTROL

General Considerations

In the foregoing pages details of cancer facilities and service in Wisconsin have been set forth. Before entering upon the discussion of a program for the prevention and control of cancer, it may be well to give brief consideration to some of the general problems in connection with this disease.

Cancer is the most lethal of all diseases. It never terminates in recovery as do acute and contagious diseases. Unless treated early and adequately, the chances of a fatal termination are almost 100 per cent. Authentic cases of spontaneous cessation of growth are so few as to be in the realm of medical curiosities, and according to Dr. James Ewing of New York, the number of authentic cures of cancer by means other than surgery, x-ray, or radium, or a combination of these is equally rare.*

Deaths from cancer are increasing annually. Statisticians may debate whether this increase is only relative or whether there is an actual increase in the rate of incidence of the disease, but this question is not of so much importance to those interested in the prevention and control of the disease as is the fact that more people are dying of cancer each year.

The increasing percentage of the population living in the cancer age groups, as noted previously in this report, may have an influence on the increase of cancer. Statistical investigations show that the population of this country is becoming much older. Dr. Louis I. Dublin, statistician of the Metropolitan Life Insurance Company, New York, has shown this to be a fact.* During the period 1850–1920 the percentage of population fifty years of age and over has increased from 8.9 per cent to 15.4 per cent. By 1950 Dr. Dublin estimates that this portion of the population will have increased to 23.6 per cent. The results of his investigations are summarized in the following table:

	Calendar year			Ultimate stationary
Age group	1850	1920	1950	population
Under 20 years	52.5	40.7	32.7	29.0
20 to 50 years	38.6	43.9	43.7	40.0
Over 50 years	8.9	15.4	23.6	31.0
Total	100.0	100.0	100.0	100.0

Cancer is no respecter of social or economic groups. While it falls with more economically disastrous results on those in the small income class, as does all other incapacitating illness, it is found with equal frequency among the well-to-do. In this country the estimated annual loss from this disease due to death and incapacity is $800,000,000.

There is no known specific etiology, although it is now accepted by all scientific workers in the field that chronic or protracted tissue irritation, mechanical, chemical, or thermal, is one of the principal causative factors. There is no accepted proof that heredity plays any important part in causing this disease, neither has environment any influence except in a few instances where occupation has shown a close relationship to cancer. Cancer of the bladder among aniline workers, chimneysweep's cancer, and

* Causation, Diagnosis and Treatment of Cancer. The Beaumont Foundation Lectures (Series Number Ten) Wayne County Medical Society, Detroit, Michigan, 1931. P. 85.

* New York Times, January 4, 1931.

tar cancer among petroleum workers have all shown a rather close relationship to the materials worked with.

Studies on the incidence of cancer have shown about three living cancer cases for every death from this disease. Such surveys have also shown that there are approximately two or three living cancer cases for each licensed physician.

The only recognized treatment methods are surgery and irradiation by x-ray and radium, either singly or in combination. The treatment of cancer along the lines recognized as most adequate requires special facilities and equipment. For this reason it is advisable to look for treatment to a few special hospitals able to provide the necessary facilities rather than to attempt cancer service in all hospitals regardless of the facilities, or rather the lack of facilities available. The facilities are beyond the means of the average hospital and private practitioner and can be provided only by generous endowments from either private individuals or governmental agencies.

In addition to the provisions for the actual treatment of the disease by one or more of the means mentioned above, a well rounded cancer service program includes complete records of the service rendered and a follow-up system whereby the history of the patient is available over a period of years following treatment. These patients should be followed, if possible, during the remainder of their lives, but in any event, this follow-up should be maintained for a minimum period of five years.

A large number of human cancer growths are external and easily recognized by those with training and experience in the treatment of the disease. It has been stated that one-third of all cancers occurring in men and one-half of those seen in women fall in this class. In this group are included cancers of the cervix and of the rectum.

Sufficient authentic evidence is now available to show that when treated during its early stages, that is, while the lesion is still confined to its original site and without evident matastasis, permanent relief is secured in a large percentage of cases. If the disease is first seen and treated late in the course of the disease, the chances of permanent relief are very greatly reduced. The major emphasis on methods of controlling this disease should be placed on early recognition and early adequate treatment. To accomplish this end, the education of the two groups most concerned, the medical profession and the public, is necessary.

In discussing the scope of the cancer problem from the educational standpoint, Dr. William H. Welch of Baltimore, has said that:

> "Cancer is today the outstanding problem in medicine and public health; it threatens the ascendancy of all other causes of death; its study engages the attention of workers in all fields of medicine and surgery and does not escape the attention, even of biologists remote from medicine; the increase of opportunities for such study makes an especially strong appeal for more generous financial support; and education both of the medical profession and the public is the most essential part of the present active campaign for the prevention and cure of cancer."*

Education of Medical Profession

The medical profession must be taught to recognize cancer in its early stages and to give adequate treatment after the case is properly diagnosed. The public should not be educated to the point of wanting a type of cancer service that the medical profession cannot supply because of its lack of training and experience in the cancer field. Should this situation arise, the public demand for cancer service will be met undoubtedly by some form of legislation to provide this service under state supervision, if not state control. Such action will take this question out of the hands of the medical profession where it properly belongs. Doctor Francis Carter Wood, Director of the Cancer Research Institute of Columbia University, New York, has stated that:

> "The extensive education of the lay public which has been conducted in the past fifteen years has created a situation not without interest to the medical profession as a whole. The fact is that while it is perfectly possible to have the lay public absorb a certain amount of information concerning the symptoms of cancer, after such absorption has taken place and the

* Cancer, p. iv.

desired reaction occurred, the profession is not in a position, speaking generally, to render efficient service to those who apply for it. In other words, the medical profession as a whole is not prepared accurately to diagnose the disease which it is called on to treat, at a stage which permits of effective therapeutic attack, nor are all surgeons or radiologists prepared to offer the proper therapy.

"The physician can be trained only by seeing patients. Cancer patients form only about 3 or 4 per cent of the admissions to a general hospital. Therefore at any one time in such a hospital there are only a few patients with tumors for teaching purposes. A better place is the radiotherapeutic department, but this contains a large number of those who have been operated on, and therefore the instructive diagnosis of the early cases cannot be offered. The solution of the problem will be found only when either the community or the medical profession realizes the absolute necessity of concentrating a large number of cancer cases in institutions in order that research and education can go hand in hand with the best therapy. The physician must train himself in the reading of roentgenograms, in the use of the instruments for inspection of the accessible internal regions, such as the eye, the throat, and the larynx, and especially in the use of the sigmoidoscope and even the cystoscope.

"It is useless to educate the public unless the profession can meet the demands so stimulated, and the profession cannot do so unless the facilities both for the undergraduate and for postgraduate instruction are developed far beyond their present status."*

Doctor S. C. Harvey, Professor of Surgery in Yale University Medical School, has said:**

"The necessity for an intensified attack upon the problems arising from cancer in man becomes daily more apparent. With more accurate vital statistics, with the more refined methods of diagnosis, and with the drop in mortality rate as a result of the control of the diseases incidental to infancy and early adult life, the morbidity and mortality from cancer, which strikes at the time of life when a person's experience has matured but when his work is only half done, are becoming appalling. The economic loss is secondary only to the suffering entailed in the individual and in those about him.

"In former years, when the importance of this problem was less apparent, the individual person with this disease was carried in the general load of medical and surgical work with the result that the attack was desultory and ineffectual, and general opinion was extremely pessimistic as to the outcome in the individual case. However, in the last decade everywhere throughout the civilized world, the investigation of cancer has been broadened and intensified, and the plan of attack upon its occurrence in man has gradually developed. The anti-tuberculosis crusade of the previous generation has in many ways served as a model and an inspiration, for, though the problems differ in some respects, they are common in that the attack must be concerted, and organized and centered about early diagnosis, the provision of adequate facilities, and the development of specialized professional care.

"That this is taking place in different ways in various countries, as a result of the national temperaments and the political organizations, is well. In the United States these factors have led to spasmodic and uncoordinated efforts which have but served to bring out the difficulties of the problem. It is necessary that we understand what is being done elsewhere and not rest satisfied in a chauvinistic self-content."

Dr. John W. Spies, in an article discussing cancer organizations in various European countries, has said:*

"The attitude of hopelessness must be abandoned by physicians and be replaced with reliable information; an optimistic, constructive effort for progress must supplant a pessimistic, destructive passivity. No giving-up should be countenanced; investigation should proceed along all lines. The dissemination of knowledge and the fostering of good-will among the physicians and the people should be one prime objective of any cancer center."

Education of the Public

The public must be taught the hopefulness of early treatment of cancer so that it will seek medical advice and secure treatment during the early stages. Both the profession and the public must be educated to a recognition of the early signs and symptoms of the disease and to an appreciation and a belief in the possibility of effecting a cure when the disease is seen and treated in its early stages. Too long a period still remains between the time the patient first notices something wrong at the site of the cancerous growth and when a physician is first consulted. A survey made in Massachusetts in 1925 showed that the average cancer patient

* Journal American Medical Association, p. 1141, October 18, 1930.

** The Yale Journal of Biology and Medicine, July 1931, p. 533.

* Yale Journal of Biology and Medicine, July 1931, page 546.

consulted his physician eight months after knowledge of the first symptoms of the disease and that cancer patients, who had surgical treatment and ultimately died, waited more than ten months after the first symptoms before having an operation.

A survey of the records of admissions to the Barnard Free Skin and Cancer Hospital in St. Louis, Missouri, in 1930 showed that patients with cancers of the lip waited approximately one year before applying for treatment. Breast cancer patients waited approximately ten months, those with cancers of the cervix nearly six months, while those with cancers of the skin, the most easily recognized of all, waited from twenty to twenty-four months before seeking medical attention. No further evidence is necessary to emphasize the need for additional constructive educational work regarding the necessity for early diagnosis and treatment of this disease.

There are two outstanding fallacies held tenaciously by many people. The first of these, that cancer from the beginning is an incurable disease, is also believed by too many physicians. The second false belief is that the presence of cancer signifies a social disgrace, comparable to or exceeding that of venereal disease. A belief in one or both of these fallacies is the reason why so many people conceal the fact that they have cancer.

Often coupled with one or both of these false impressions is the fear of many people that they have the disease, a "cancerphobia" so called. Knowing something is wrong, the person delays seeking medical attention and examination for fear he may be told he has cancer. An enlightened public, educated to the truth about cancer, will gradually dispel these fallacies and fears. A few morbid individuals will continue to worry about having the disease, but in the absence of the disease, never will die from the belief that they have it. If they do not worry about cancer, they will worry about something else.

Physicians should be much more concerned over the type of cancerphobia that keeps patients away from them than over the morbidly introspective individual who is always experiencing discomfort from imaginary illnesses. Investigations have shown less than three percent of those applying to certain cancer hospitals have an imaginary malignancy. Surely the other 97 per cent or more should not be dismissed as cancerphobes when their intelligence has directed them to institutions adequately equipped and staffed for the diagnosis and treatment of the disease.

Cancer a Public Health Problem

Cancer is beginning to be considered a public health problem and seven states, Florida, Kansas, Louisiana, Mississippi, Montana, Nevada, and Oregon, now have laws making it a reportable disease. With cancer pushing hard for first place as a cause of death throughout the country, it would seem desirable that public health officials take notice of its occurrence and provide means for its study and, as far as possible, its prevention and control.

In discussing this phase of the cancer problem before the Twenty-seventh Annual Conference of State and Territorial Officers with the United States Public Health Service in 1929, Dr. James Ewing, Professor of Pathology of Cornell Medical College, New York, said:

> "The important thing to know today is that the exciting factors of some of the major forms of cancer are well known, are very simple, and are often controllable. The old French clinicians thought cancer of the mouth, which kills 3,500 yearly in the United States, was caused by tobacco, bad teeth, and syphilis, and that if these three exciting factors were removed, cancer of the mouth would disappear. Instead of waiting for sensational discoveries in biology, we ought to be acquainting ourselves with these exciting factors in the major forms of human cancer which are accessible, controllable, and which, if dealt with intelligently, would result in a reduction in the incidence of cancer. On the whole, there is a very substantial body of knowledge regarding the various forms of chronic and specific irritation which are known to be necessary to the incidence of cancer. The exciting causes of several of the major forms of cancer are numerous and very commonplace. One conclusion that can be drawn from such information is that cancer is a public health problem of the first importance because many of the forms of cancer are preventable, and if the public were thoroughly informed, a definite reduction in the incidence of cancer might follow.

"There are two ways in which public health officials and organizations may help essentially in the program of cancer control, and these are disseminating to the public the knowledge of the causes of cancer as they are known and of the early signs of the different forms of the disease, and in furthering the effort to provide proper facilities for the treatment of cancer."

Cancer Morbidity Statistics

Cancer morbidity statistics in general, are wanting and the only information available on the cancer problem is that given by the mortality statistics. Morbidity figures are needed to check death certificates, to stimulate earlier diagnosis, to raise the standards of treatment, and to augment our clinical knowledge of the disease.

For some reason the collection of morbidity statistics has been ignored by the agencies most concerned in this work. A few hospitals are now specializing in cancer treatment and it is from these that available statistics are now being received. However, it will be necessary to increase the sources of this information much beyond their present number and scope before their value will in any way approach that for other diseases.

In the absence of definitely known etiological factors, the most promising attack on this disease is through the collection and analysis of all possible information bearing on the disease. Hospitals and clinics and physicians in private practice should take full advantage of their opportunities to record in detail the factors both primary and collateral that relate to their cancer patients.

ORGANIZED CANCER SERVICE

In cooperation with the American Society for the Control of Cancer the American College of Surgeons, through its Committee on Treatment of Malignant Diseases, has outlined the following types of institutions for the treatment of cancer:

1. Cancer Institutes.
2. Cancer Research Laboratories.
3. Cancer Hospitals.
4. Cancer Clinics in General Hospitals.
    a. Complete cancer clinics.
    b. Diagnostic cancer clinics.

The descriptive quotations that follow are taken from the pamphlet of the American College of Surgeons, entitled "Organization of Service for the Diagnosis and Treatment of Cancer."

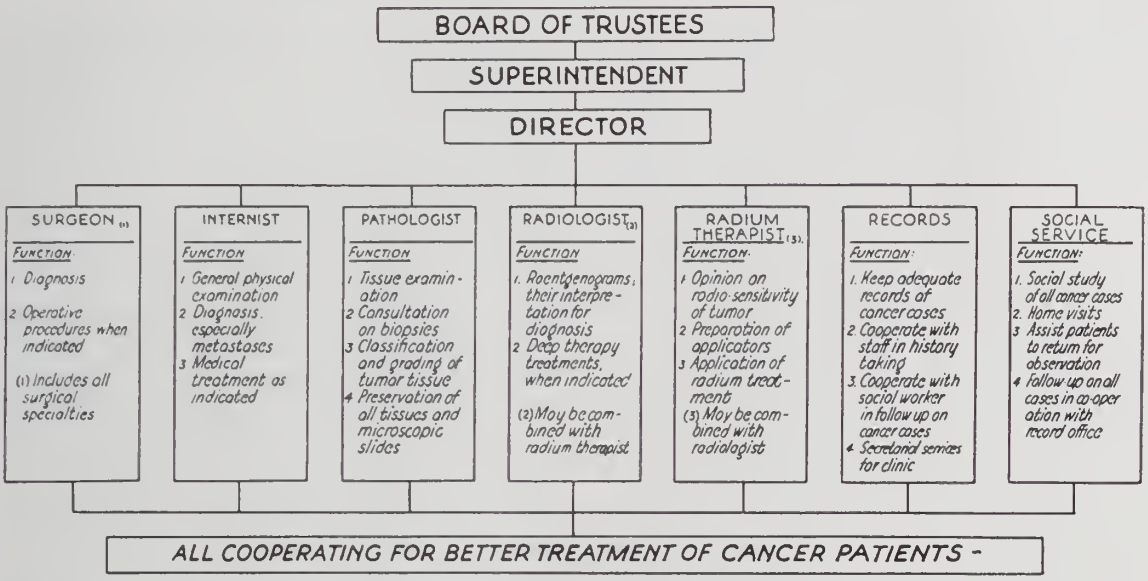
Cancer Institutes: "A cancer institute is an organization equipped with hospitals and laboratories especially organized and conducted for carrying on research in relation to the nature of cancer and its diagnosis and treatment, as well as for the clinical diagnosis and treatment of actual cancer patients. Institutes of this nature require very considerable endowments or such generous annual appropriation as can be obtained usually only from the state or national government. They are undoubtedly the most effective method of dealing with the cancer problem, but their cost is such that their number will inevitably be somewhat restricted."

Cancer Research Laboratories: Cancer research laboratories "are dependent on large endowments and devote themselves to the investigation of cancer by experimental methods with a view to obtaining knowledge in regard to the nature of the disease. Research of this character is of the greatest importance in contributing to a better control of the disease than is available at the present time, but it is only after a long period of experimentation that the results obtained in the laboratories can be made effective in the actual treatment of the disease of human beings.

"These research laboratories may very appropriately be operated in connection with a cancer institute, as it is from the latter that the clinical and pathological material necessary to carry on their work successfully will be drawn.

Cancer Hospitals: "Cancer hospitals are devoted exclusively to the diagnosis and treatment of cancer and allied diseases. There are probably not more than twelve such hospitals in the United States. Such hospitals should have in addition to the usual clinical facilities plenty of space, equipment and personnel for laboratory research and also deep therapy x-ray equipment of at least 200,000 volts effective capacity, and a supply of radium sufficient to meet all clinical and research needs. It is desirable that there should be at least 1,000 milligrams of

CHART OF ORGANIZATION FOR CANCER SERVICE IN GENERAL HOSPITALS



radium, half of which should be in solution for the production of radon.

"Such organizations again require very considerable financial support either by an endowment or by an annual appropriation. Hospitals of this nature may be supported by the state departments of health, as in Massachusetts, by state universities, as in the Cancer Institute of the University of Minnesota, or partly by endowment and partly by annual subscription, as in the case of those organized under private enterprise."

Cancer Clinics in General Hospitals: "Where funds for the maintenance of cancer institutes, research laboratories, or special cancer hospitals are not available, the demand for improved cancer service has resulted in the organization of special clinics in existing general hospitals and of cancer diagnostic clinics in many places in the country in the past few years. The reason for the organization of these special cancer clinics is primarily the fact that the field of cancer diagnosis and cancer treatment has developed so widely in the past few years that only by the organization of a group of representatives of the different departments of the hospital can the full resources available at the present day for the treatment of cancer be made accessible to the individual patient. Many general hospitals are equipped with the material and apparatus needed for the treatment of cancer, including high voltage x-ray and a sufficient amount of radium, but a separate organization is required to make this equipment available for the cancer patient and to secure the necessary consultation and cooperation from the different members of the hospital staff who are interested and competent in this field."

Minimum Standard: After outlining the different types of institutions for cancer work, the American College of Surgeons promulgated minimum standards for cancer clinics in general hospitals.* These standards are such that they can be put into effect in whole or in part as the local conditions indicate. They are as follows:

> "1. Organization—There shall be a definite organization of the service, and it shall include an executive officer and representatives of all the departments of the hospital which are concerned in the diagnosis and treatment of cancer. The services of a secretary and of a social service worker shall be available.
>
> "2. Conferences—As an essential feature of the service, there shall be regular conferences or consultations at which the diagnosis and treatment of the individual cases are discussed by all members of the clinic who are concerned with the case.

* Surgery, Gynecology, and Obstetrics, June, 1931. Also published as a separate pamphlet by the College.

"3. Patients—Reference to the cancer clinic of all patients in whom the diagnosis or treatment of cancer is to be considered shall be either voluntary or obligatory in accordance with the vote of the medical staff or of the governing board of the hospital.

"4. Equipment—In addition to the diagnostic and therapeutic surgical equipment which is required in every approved general hospital, there shall be available an apparatus for x-ray therapy of an effectiveness which is generally agreed upon as adequate, and an amount of radium sufficient to insure effective treatment.

"5. Records—In addition to the records which are required in every approved general hospital, there shall be additional records of:

"(a) The details of the history and of the examination for cancer in different regions of the body, such as are indicated on the form records which are recommended by the Committee on the Treatment of Malignant Diseases, American College of Surgeons.

"(b) The details of the treatment by radium or x-ray as indicated on the form records which are recommended by the Committee on the Treatment of Malignant Diseases, American College of Surgeons.

"(c) Periodic examinations at intervals for a period of at least five years following treatment.

"6. Treatment—The treatment of cancer patients shall be entrusted to the members of the staff of the cancer clinic except in cases in which adequate treatment in accordance with the collective recommendation of the staff of the cancer clinic can be procured otherwise."

The required x-ray and radium facilities set forth in the Minimum Standards are that the deep therapy must be of at least 200,000 volts effective capacity and the amount of radium 200 milligrams of the salt or an equivalent amount of emanation.

The pathological department should be equipped and staffed to give "not only the pathological diagnosis of cancer but also further details in regard to classification of the type and degree of malignancy and, where possible, an estimate of the radiosensitivity of the tumor".

In addition to the special staff organization and the diagnostic and therapeutic facilities mentioned above, the operation of such a clinic requires an adequate record system, clerical assistants, and social service workers. Adequate records of cancer cases should be kept in a uniform manner so that comparative studies of the records can be made in later years. Clerical assistants are necessary to maintain such records and social workers are needed to follow the cases over a protracted period.

Social service work with cancer patients is of primary importance in an acceptable and complete cancer service. Some authorities state that no efforts should be made to organize a special cancer service until trained social workers are available. It is most important that all cancer patients be carefully followed over long periods subsequent to their treatment either by private physicians or by hospitals. At the present time there is too little known about the health of cancer patients after treatment and, as a knowledge of their subsequent condition is the only practical criterion of the effectiveness of such treatment as has been given, it is most essential that facilities be provided for obtaining regular periodic information regarding such cases.

This work can best be done by a well-trained and experienced medical social worker. Without infringing in the least upon the rights and prerogatives of the physician who has attended the case, information can be obtained regarding the patient's condition.

Another factor that should be given consideration in this connection is that physicians are reported to be experiencing greater difficulty in keeping their list of patients intact. Many patients, particularly those with chronic and slowly incapacitating diseases, are reported to be consulting an increasing number of medical men regarding treatment. Because of this fact it becomes increasingly necessary to have accurate and complete information regarding the health of such persons, particularly those afflicted with cancer.

It may be of interest to point out a plan for follow-up that has proved successful in the hands of a capable surgeon. After the surgical treatment has been given, this surgeon outlines a plan for follow-up in which the patient is advised that the initial surgical fee covers all regular follow-up visits, but not subsequent surgical interference if it is found necessary. The patient is asked to return monthly for observation for a year, then every two months for the second year, every three months for the third year, and

then semi-annually for as long as possible. The patient is also advised that if this plan is not followed regularly, charges will be made for examinations at irregular intervals.

The organization of a follow-up service through medically trained social workers will not only relieve the physician of a responsibility which at times is most difficult for him to discharge, without seeming to be too solicitous about his patients, but it will also provide him with information essential to the improvement of his practice and will assist in the gathering of data most necessary to a further and better understanding of present methods of diagnosis and treatment of cancer patients. Social service follow-up of cancer patients is not a new undertaking in the medical field. In those institutions where it has been utilized for years, reliable statistics are now available on patients treated 15 to 20 years ago, and such statistics form some of the most valuable background we now have on this subject.

It would be well for all hospitals accepting cancer patients for diagnosis and treatment to have a social service department adequately staffed to which such patients would be referred on discharge for regular follow-up investigation. It is only by the accumulation of a largely increased volume of information and statistical data on the condition of cancer patients following treatment that improvement in diagnostic and therapeutic technique can be brought about.

Cancer Diagnostic Clinics

Hospitals, unable to meet fully the requirements for a cancer service, but which have members of their staff interested in cancer and a laboratory with equipment and personnel able to interpret the histological findings, may offer a cancer diagnostic service that would be of value to the community.

"Cancer diagnostic clinics may be organized in smaller communities where modern x-ray equipment and an adequate supply of radium is lacking. The object in establishing such a clinic is to provide better diagnoses upon cancer patients, to furnish a group judgment concerning the proper means of therapy to be employed, and to educate the medical public concerning this important group of diseases. Medical men in the community should be encouraged to bring patients to such a clinic, accompanied by a complete record of the history and physical examination. When a diagnosis shall have been reached and a line of treatment suggested, the surgeon or physician will be free to continue the care of his own patient as he may see fit.

"The most important activity of such a clinic is the conference held at least once a week. The conference permits a free exchange of ideas and eliminates the special bias of any one individual in dealing with a patient. The diagnosis of cancer may be extremely difficult and the best judgments rendered are by groups of men interested in this subject. At such a conference interesting pathological material may be presented. The members of the clinic and the physicians in the community should be encouraged to present in the conference patients who have been previously seen and have been subjected to various forms of treatment. The conference, therefore, becomes an important educational activity of the clinic."

The American College of Surgeons will cooperate with cancer clinics in the following ways:

"It will furnish to men and hospitals desiring to form such clinics information as to the methods to be adopted in the organization of the clinics.

"It will put the stamp of approval of the College on such clinics as conform to the standards of the College for such clinics.

"It will furnish to the clinics samples of uniform record blanks for the recording of their cases.

"It will ask the clinics to cooperate in furnishing data on their cases for a specific study of the results of treatment by various methods. This study will be a continuation of the studies that the Committee has been making during several years on data furnished by a limited number of selected clinics.

"It will furnish the clinics with an opportunity of discussing their administrative problems in a series of round table conferences at each of the annual Clinical Con-

gresses of the College which are held throughout the country each year.

"It will publish and distribute to the clinics the results of its studies, based on data collected, after analysis by the Committee.

"It will issue in the Bulletin of the College from time to time articles dealing with the administrative and scientific phases of the clinic work, and the proceedings of such round table conferences and symposiums as may be held.

"It will cooperate with the clinics in such other ways as may be to their advantage."

CANCER PREVENTION AND CONTROL

The following facts bearing on the cancer problem in Wisconsin have been developed in this survey.

While the general death rate of the state is declining, in keeping with other sections of the United States, the cancer death rate is rising steadily. From 1908 to 1930 the cancer death rate in Wisconsin as a whole rose from 65.9 to 114.7 per 100,000. In Milwaukee the rate increased from 68 to 110 per 100,000. In general the urban death rate is rising faster than the rural death rate, but it is noted that the trend of the death rate for Milwaukee does not bear out the statement just made when compared with the state as a whole.

As far as it is possible to determine from this survey, approximately 2,416 cancer patients were treated in 1930 in the general hospitals of Wisconsin having a capacity of 50 beds or more each. Of this number, 557 died and 188 came to autopsy.

All the general hospitals in Wisconsin admit cancer patients for treatment.

There were no organized cancer services in Wisconsin hospitals at the time of this survey. With present facilities but few hospitals in the state could qualify for special cancer service along the lines recommended by the American College of Surgeons. This lack of specially organized facilities for cancer work makes it impossible to utilize to the best advantage many of the cancer patients for undergraduate and postgraduate teaching. As has been pointed out previously, the average general hospital admits not more than two per cent of its adult patients for cancer and the average physician sees but few cancer patients in the course of a year. For these reasons it would seem desirable from the standpoint of adequate diagnosis and treatment that an effort be made to concentrate cancer patients in a few institutions having adequate resources, equipment, and personnel to care for them in keeping with present day conceptions of proper methods. It is only logical that better service can be rendered in institutions adequately equipped and by physicians who have had extended experience with such cases.

Another reason for the concentration of cancer treatment facilities is the better educational opportunities for undergraduate and postgraduate education in the prevention and control of this disease. It is believed that although the general public has not yet taken a serious interest in the question of cancer prevention and control, the time is not far distant when such an interest will be manifest. When this time comes the medical profession should be fully informed and ready to assume a larger responsibility in meeting the needs of the situation. Proficiency in the diagnosis and treatment of cancer can be acquired only by a careful and extended study of patients. The time necessary to accumulate authentic information on cancer cases is so long, owing to the necessary protracted period of observation following treatment, that the education of the physician and his preparation for handling such cases must also be extended over a considerable period of time. The profession should keep this fact in mind and around it organize its educational activities in the cancer field in order to be ready for the larger part it surely will be called upon to play in the future control of cancer as well as to provide the best possible service to cancer patients at this time.

Having in mind primarily increased opportunities for undergraduate and postgraduate cancer education, it would seem desirable that special cancer services be organized in the State of Wisconsin General Hospital at Madison for the benefit of the students in the Medical School of the University of Wisconsin and in Milwaukee County Hospital for the benefit of students

in the Medical Department of Marquette University. Enough indigent patients are cared for in these two hospitals to provide sufficient material for teaching purposes without in any way encroaching upon the domain of the private physician with the pay patient.

In addition to the two special cancer clinics suggested for Madison and Milwaukee, it is believed that, at this time, better organization for cancer service could be developed in one or more hospitals in Milwaukee, in Eau Claire, La Crosse, Marshfield, and Fond du Lac. As the special service in the state hospital in Madison primarily would be for indigent patients available for teaching purposes, it might be well to have an organized cancer service in another Madison hospital to which pay patients would be admitted. Patients from Superior and elsewhere in northwestern Wisconsin doubtless will be cared for in an organized cancer service in Duluth, Minnesota.

Aside from the state hospital in Madison in none of the cities mentioned are there facilities in any one hospital to comply with the minimum standards of the American College of Surgeons, but by obtaining some additional equipment, such as more powerful x-ray apparatus or an additional quantity of radium, the minimum requirements of the College could be met.

What has just been said is without criticism of the professional qualifications of physicians or hospitals in other communities. Because of the lack of facilities in other communities for an organized cancer service or because the number of cancer patients treated in the hospitals of such communities is hardly large enough to warrant the added expense, an organized cancer service is not suggested. All assistance possible should be given to all hospitals and their staffs wishing to provide an improved service to cancer patients in order that the best service within the limits of their resources may be rendered to such patients.

The organization of these special cancer services in the localities mentioned calls for cooperative effort on part of the local medical profession regardless of past or present interests. As any program of improved cancer diagnosis and treatment rests on the subordination of personalities to a better service to the patient the development of such a program rests absolutely with the local medical profession. If an agreement cannot be reached for cooperative effort in such an undertaking the plan would better be deferred until such time as cooperative effort can be established.

Practically all hospitals owning no radium have to depend on local private or out-of-town supplies. Radium available locally, though not owned by the hospital, is preferable to depending on rented radium sent in from the outside. Local supplies doubtless can be obtained for a smaller charge to the patient and their use more likely will be in the hands of the same physician than if the radium is ordered from a distance. Then too, as the number of cancer patients increases the radium would be in more constant use, making it desirable, if not necessary, to have a local supply that could be used in the varying amounts and in the different forms of applicators called for.

The attempt to develop a special cancer service in hospitals without laboratory equipment for tumor tissue diagnosis or personnel to interpret such examinations would be a procedure of doubtful value. A false sense of security in the reliability of diagnostic procedure would be engendered that would make for delay in securing adequate treatment in many cases.

Opportunity should be given the different members of special cancer service groups to obtain additional training in their specialties by spending a definite period each year in study in other and larger institutions. Funds for this purpose, if not otherwise available, might well be supplied from private sources and obtained through the efforts of the State Committee of the American Society for the Control of Cancer or its local branches.

The faculty of the Medical School might well cooperate with the Extension Division of the University in the organization of courses in the diagnosis and treatment of cancer along the lines of similar courses on other subjects offered in the past.

Staff physicians and hospital executives, especially in those hospitals where a consid-

erable amount of cancer work is being done, should be encouraged to obtain additional training in cancer diagnosis and therapy and in the operation of cancer services for the benefit of the work in their own hospitals.

The organization of a special group of physicians for the diagnosis and treatment of cancer should be based on two fundamental considerations. The first is the better service such a group can render to the cancer patient through combined diagnosis and opinion as to treatment; the second, the opportunity offered for educational work in cancer for professional and related groups.

Given the proper facilities for cancer diagnosis and treatment, the successful initiation of the program depends on the active interest of one or more members of the hospital staff. This must be a compelling interest that will not stop to count the cost in time and energy necessary to carry the plan forward. The pathologist, the radiologist, the surgeon, and the internist, each must be willing to contribute generously of time and talent to give the undertaking the proper impetus. Just which member of the group becomes the director depends on the local situation. The surgeon doubtless will be found to be the one in many cases. The pathologist, because of his removal from active clinical treatment, has much to recommend him for the place. No matter who is chosen, the selection should be on the basis of active interest in the work, executive talent, and ability to win the cooperation of other members of the special group and the general hospital staff.

The question of treatment of pay patients always arises when an organized cancer service is discussed. Obviously, for the good of the patient, the same type of organization should be available for pay patients as serves the indigent group. The ability to pay should not deprive a cancer patient of the advantages of the organized service.

It has been suggested that a physician with a paying cancer patient should refer this patient to the special service for diagnosis and advice regarding treatment. The actual treatment procedures will then be carried out by the referring physician as he may choose. This plan will give both the patient and the physician the advantage of group opinion on the case.

Another suggestion has been that all cancer patients receive both diagnosis and treatment by the special group. In such a plan the referring physician should reasonably expect reference to him of non-cancer cases seen by members of the special group so that there may be the most equitable reference of cases possible.

No definite rule can be laid down for the detailed control of such matters. Local conditions in hospitals and medical practice must dictate the plan to be followed. Fee arrangements between the referring physician and the special cancer group also will depend on local conditions. Ways can be found for the care of pay patients in a special cancer service, but the development of a plan rests with the local profession and the hospitals.

In addition to the professional facilities suggested for the specialized cancer service in a general hospital, there should be provided an adequate record system for recording not only the regular data found on all well kept hospital records, but additional information regarding cancer. To be of the most value, such records should be comparable to those kept in other hospitals so that an increasing volume of accurate information on cancer gradually will develop. The American College of Surgeons has fomulated a cancer record that it will gladly place at the disposal of any hospital interested in this work. This blank offers a uniform method of record keeping and may well form the basis of any type of record form adopted in an organized cancer service.

There should be provided also in this diagnostic and treatment center facilities for the follow-up of all cases. These facilities should include medically trained social workers and a sufficient clerical force to keep in touch with all cases coming for diagnosis or treatment. Those cases referred by private physicians would, of course, be followed only through these physicians or with their full knowledge and consent. Cases referred by other agencies would be followed through the regular channels. This follow-up service is of special significance and importance in

cancer work for through it is offered the most adequate criterion of the effectiveness of cancer treatment available to-day. There is still lacking an adequate body of authentic statistics on cancer treatment and it is only by the organized follow-up on an increasing number of cancer patients that sufficient evidence will be produced to bring about an improved service in this field. There are also great possibilities that the intelligent use of such facts as are brought out by an adequate follow-up service will contribute to the solution of the problem of prevention and control of this disease.

It is believed that the pathologists in Wisconsin hospitals who are called upon to examine and interpret tumor tissues would profit from periodic meetings of a day or more each for the purpose of acquiring greater proficiency in their work. Such meetings would give each pathologist the benefit of the opinions of his colleagues on any doubtful tissues which may have been submitted for interpretation. Such meetings also would serve to develop a greater unanimity of method and uniformity of procedure that would be of benefit to all concerned.

As mentioned previously in this report, the training and experience necessary on the part of a pathologist to give accurate interpretation of tumor tissue is much beyond that requisite for many other branches of clinical pathology in which he may be called on to serve. For these reasons a more extensive training is required for skill in tumor tissue examination and the physician who equips himself for this form of medical practice should be granted better recognition in the staff organization than he now receives in many hospitals. It should also be borne in mind that as he is unable to share in the fees collected by the surgeon or diagnostician, although a major responsibility for proper diagnosis and treatment often rests upon him, he should receive remuneration in keeping with these responsibilities. The point of this discussion is, that in an adequate diagnostic cancer service, the pathologist is one of the key men and that men competent in this field cannot be expected to enter it or to remain in it unless their position is recognized and their remuneration more in keeping with their ability and responsibility than now prevails in many cases.

The provision of adequate diagnostic and treatment facilities for cancer patients is beyond the reach of the average general hospital from current resources. A few hospitals with very large endowments could, possibly, meet such expense but they are few compared to the large number of well administered institutions that are unable to stand such a heavy drain on their resources. Therefore, assistance in meeting this need can be expected from two sources only: private philanthropy or legislative appropriation. Of the two, the former is much to be desired, as the funds so obtained usually will be larger in amount, of a more permanent nature, and with fewer political and other entangling alliances to handicap their administration. Public funds must depend on the whims and policies of appropriating bodies and be subject to fluctuations in amount as the plans of the immediate administration may dictate. On the other hand, the support of cancer work by taxation places the disease in the public health group and distributes the burden among the entire population, which, by reason of this participation, may have a greater interest in the subject than if it is left to the generosity of one or a few community-minded persons.

There is abundant precedent for the plan of government appropriation for this work. It is but necessary to turn to the fields of tuberculosis, child welfare, or communicable disease control to find examples of participation by state appropriated funds in health and medical matters.

Probably at this time emphasis should be placed on efforts to obtain private funds for the equipment of special cancer services as further participation by the state in medical affairs will but aggravate the vexed question of state medicine. It should be borne in mind, however, that with an increased knowledge of cancer on the part of the public there must be a correspondingly increased interest in its better diagnosis and treatment on the part of the medical profession and the hospitals if active participation by the state in the control of the disease is to be avoided. The work in Massachusetts and New York,

referred to subsequently, and the fact that seven other states, Florida, Kansas, Louisiana, Mississippi, Montana, Nevada, and Oregon, now make cancer a reportable disease, are but indications of the trend of the times in governmental dealing with this question.

The best methods of meeting the cancer problem have not yet been developed. The medical profession should have an opportunity to show what it can do and should be given a reasonable time in which to do it. If it fails, and recourse to state help is found desirable, the approach to such authorities should be through medical channels.

The control of cancer is still in the hands of the medical profession and the hospitals where it properly belongs. The interested public should confine its efforts to strengthening the resources of these two groups and to constructive, conservative and convincing educational work among the laity in order that cancer patients may learn to come for examination at the earliest possible moment and while there is the greatest opportunity for obtaining permanent relief.

The medical profession should think and act collectively on this question, should appreciate that cancer is not a "one man" disease but requires the best thought and skill of a special group for its care and treatment. The profession should also be stimulated by the thought that cancer is one of the few diseases, if not the only one, in which medical skill alone must be relied on to bring about a cure. Practically all other diseases run their course little influenced by the therapeutic skill and attention given by the physician. The patient either recovers soon or dies. In cancer, however, the physician has an opportunity by his skillful removal of all vestiges of the disease, either by surgery or irradiation, to place that patient permanently out of all danger of death from its effects.

Cancer is the greatest challenge now before the medical world. Its wide distribution and increasing mortality demand the best thought of all scientists and it is only by concentrated and cooperative efforts that the problem will be solved.

Cancer is being given very little attention by either the state or local health departments in Wisconsin. Aside from publishing statistics on the number and distribution of cancer deaths, the health departments occasionally distribute some educational matter to the public through bulletins or the general press.

The State Departments of Health of Massachusetts and New York, and the Health Department of Detroit, Michigan, now have cancer divisions. The Bureau of Hospitals of New York City has a Division of Cancer Clinics and Research. In view of the position now held by cancer as a cause of death in Wisconsin, the State Department of Health might well consider the organization of a Division of Cancer Control. Such a Division could carry on investigations in the prevention and control of cancer, the analysis of hospital records, of autopsies, and of death certificates, and their correlation for the presentation of accurate statistics of the cancer situation in Wisconsin. Such studies and correlations could do much to improve hospital diagnosis and practice and would also supply an abundance of material for public education in the prevention and control of this disease.

The State Medical Society of Wisconsin can make an important and effective contribution to cancer education in the state by close cooperation with the two medical schools and the Extension Division of the University in efforts to bring post-graduate medical instruction to the physicians of the state. For promoting the interest of its members in cancer diagnosis and treatment, the Society should urge at least one cancer program annually before each local and district society. It should feature cancer topics in the form of a symposium before one session of each annual meeting. Suitable exhibits on cancer might well be a feature of each annual meeting.

The Wisconsin Committee of the American Society for the Control of Cancer can assist in this educational work for both the profession and the laity by supplying literature on various topics; by the organization of meetings for the discussion of cancer by competent authorities and similar activities. Through local branches of the state committee it should be possible to render assist-

ance to such organized cancer services as are found in the community by providing educational matter, by helping to finance needed clerical assistants when the clinic is in operation, and by similar undertakings.

It would seem to be a practical and logical procedure for the State Medical Society, the two medical schools, the State Department of Health, the Extension Division of the University and the State Committee of the American Society for the Control of Cancer to cooperate in a well rounded educational program. The details of such a program will be discussed later. The above plan, if carried into complete operation, would provide for Wisconsin an adequate diagnostic and treatment service for all cancer patients within the state. It would also offer an opportunity for educating the profession in the acceptable methods of diagnosis and treatment and would provide ample material and factual information on which a public educational program could be based.

RECOMMENDATIONS

The following recommendations are made for an improved cancer service in Wisconsin:

1. There should be developed an organized cancer service in the State of Wisconsin General Hospital, Madison, and in the Milwaukee County Hospital, Milwaukee, to serve primarily as teaching centers for the students in the Medical School of the University of Wisconsin and the Medical Department of Marquette University. These organizations should attain at least to the minimum standard for cancer service in a general hospital as recommended by the American College of Surgeons.

These special cancer services also should be used as centers for post-graduate education for Wisconsin physicians and hospital executives so that in time an approved cancer service may be developed in other Wisconsin hospitals.

During each year there should be given to the physicians of the state at least one post-graduate course in cancer diagnosis and treatment by the staffs of these special services and other recognized authorities in the cancer field.

2. As far as resources of equipment and competent personnel permit, special cancer services should be organized in Eau Claire, La Crosse, Marshfield, Fond du Lac and one or more hospitals in Milwaukee. The provision of some additional equipment would enable one or more of the hospitals in each of these cities to meet the minimum standards of the American College of Surgeons. Their geographical location is such that the majority of the population of the state would be within reasonable distance of one of these centers.

Other communities should be encouraged to offer as complete service for the diagnosis and treatment of cancer as their facilities permit.

These diagnostic centers should serve as headquarters for local cancer committees and should be supplied with educational material of interest to the medical profession and the public.

3. A comparable and adequate record system should be developed for the hospitals and clinics accepting cancer patients for diagnosis and treatment. The record forms of the American College of Surgeons and the follow-up indicated thereon are recommended to the favorable consideration of the institutions undertaking this work.

4. There should be an adequate staff of medically trained social workers connected with the diagnostic and treatment institutions whose primary function would be the follow-up on cancer patients. These workers should cooperate fully with the clinical and record departments of the institution with which they are connected.

5. The pathologists in Wisconsin hospitals who are called upon to diagnose tumor tissues, especially those pathologists in hospitals with specialized cancer services, should meet periodically for a day or longer for the discussion of mutual problems and further training in tumor tissue diagnosis.

6. The facilities of the Extension Division of the University of Wisconsin should be used for further cancer educational work among medical and lay groups. Together with the faculties of the two medical schools and with the State Medical Society, an educational program should be developed that would bring cancer actively to the attention

of every practicing physician in the state. In cooperation with the State Department of Health and the State Committee of the American Society for the Control of Cancer, an educational program for the general public should be organized.

7. The Cancer Committee of the State Medical Society of Wisconsin should be made a permanent committee with a minority of its membership changing in any one year. This committee might be enlarged to include a member from each councilor district in order to establish and maintain a closer contact with the professional and hospital resources of the district. This committee should work in close cooperation with other agencies interested in cancer prevention and control, with the Extension Division of the University, and with the state and local committees of the American Society for the Control of Cancer.

The cancer committee should be specially charged with the responsibility of bringing before the profession of the state the latest authentic information on the diagnosis and treatment of cancer. At least one meeting each year of each local and district society should be devoted to cancer. One session of the annual meeting of the state society should likewise discuss cancer questions and there should be an exhibit on some phase of the cancer problem at each annual meeting.

8. There should be developed in the State Department of Health a Division of Cancer Control with adequate personnel and budget to make possible the carrying out of studies in the prevention and control of cancer, the analysis of hospital records, of death certificates, and of other information pertinent to this question.

9. The State Cancer Control Committee, operating under the auspices of the American Society for the Control of Cancer, should be expanded by the addition of representative and influential professional and lay members. Local committees of similar composition should be formed in those communities undertaking any form of clinical or educational cancer work. The chief purpose of these committees should be to arouse and maintain a sane and constructive interest in cancer prevention and control in their various communities and in the state at large. They should also serve their communities as centers of information on cancer problems.

The state and local committees should cooperate fully with all other health and educational forces in the community for the prevention and control of cancer.

10. It is believed that the needs of the cancer situation in Wisconsin will be met by the development of organized cancer services along the lines mentioned. It is realized, of course, that cancer cases will continue to be seen and treated in hospitals not equipped for cancer therapy and by physicians in their offices. It would be well, when cancer cases are encountered by institutions and physicians not equipped to give adequate service, that they be referred for treatment to those hospitals and physicians who are so equipped. In any event, an adequate record of the case should be kept and a follow-up in keeping with the recommendations made should be carried out. In the present status of cancer therapy, it is doubtful if an institution should undertake to treat cancer unless there are available adequate facilities for diagnosis, therapy, record keeping, and social service follow-up work.

11. It is believed that these recommendations for an improved cancer service in the prevention and control of cancer in Wisconsin can be most effectively brought into play at this time through the cooperation of the State Medical Society of Wisconsin, as representative of the educational and clinical phases of medicine in the state, the State Department of Health, and the Wisconsin Committee of the American Society for the Control of Cancer in a tripartite organization for cancer control. This cooperative group could weld into a strong working organization the cancer control facilities in the state to the end that all cancer patients would receive acceptable and adequate treatment in the earliest possible stage of the disease, which stage offers the greatest hope of permanent relief. The organized facilities would also offer an unexcelled opportunity for undergraduate and post-graduate education in the field of cancer diagnosis and therapy; a field that needs intensive cultivation if the best service is to be rendered to sufferers from

this disease. The effective working of such an organization would make unnecessary the entrance of any other agency, particularly any governmental agency, into the field of cancer prevention and control in Wisconsin. The contribution which each member of this tripartite organization would make and the problems on which they would cooperate in the suggested program are herewith indicated.

PROGRAM OF TRIPARTITE ORGANIZATION FOR CANCER PREVENTION AND CONTROL IN WISCONSIN

A. State Medical Society of Wisconsin

1. The State Medical Society of Wisconsin should concern itself with the education of the medical profession of Wisconsin in the most approved methods of diagnosis and treatment of cancer and allied diseases.

2. It should cooperate with hospitals and clinics to see that adequate facilities are provided and acceptable treatment rendered to cancer patients coming to these institutions.

3. It should stimulate its members to refer promptly cases which they do not diagnose or care to treat to institutions and specialists interested in such cases.

4. It should endeavor to secure better histories and records of the treatment of cancer cases and to obtain more accurate statements on death certificates as to the cause of death.

5. It should encourage its members to read papers on cancer subjects at local and state society meetings.

6. It should supply its members with reliable statistics tending to show the value of early diagnosis and early adequate treatment.

7. It should cooperate with the two medical schools of Wisconsin and with the Extension Division of the University in the organization of post-graduate instruction in cancer diagnosis and therapy for all physicians of the state.

B. State Department of Health

1. The State Department of Health of Wisconsin should make surveys to determine the character and extent of the cancer problem within its territory as to the actual number of cases and deaths.

2. It should compile statistics from the tabulation of cancer deaths by age, sex, organ, type of lesion and of the time elapsing between the patient's first knowledge of the disease and his seeking medical attention.

3. It should make surveys of the clinic, hospital, and nursing services for cancer patients in Wisconsin.

4. In cooperation with the State Medical Society, welfare, and economic organizations, it should make studies of the economic problems involved with the cancer patients of Wisconsin.

5. It should stimulate the provision of proper facilities for the pathological examination of tissues in the hospitals undertaking a specialized cancer service. Where adequate laboratory facilities do not exist for tissue examination, this service should be offered in the laboratories of the State Department of Health.

6. It should estimate periodically the amount and quality of cancer service given in the state on the lines laid down in the Appraisal Form of the American Public Health Association.

7. In cooperation with the State Medical Society, it should provide for interesting and informative articles on the question of cancer control for distribution to the laity.

8. It should cooperate with the Wisconsin Committee of the American Society for the Control of Cancer in its work of education of the public regarding early signs and symptoms of cancer and the value of early, adequate treatment.

C. Wisconsin Cancer Control Committee

1. This committee should cooperate with the State Medical Society of Wisconsin and the State Department of Health in the activities suggested for these two organizations under this tripartite arrangement.

2. It should assist in educating the public in the early signs and symptoms of cancer and the value of early diagnosis and early adequate treatment.

3. It should assist the public in ways and means of seeking skillful attention in the treatment of this disease.

4. It should teach the public the value of periodic examinations as a means of detecting cancer in its early and most hopeful stage.

5. It should educate responsible individuals in Wisconsin to the value of adequate facilities for the early diagnosis and treatment of cancer and should urge upon them the provision of funds when and where needed to supplement existing facilities for use in controlling this disease.

6. It should take a prominent part in the raising of funds to carry out the program developed by this tripartite organization for cancer control.

7. It should cooperate with all voluntary health and welfare agencies in all their constructive activities relating to cancer.

8. It should keep fully advised of the policies and programs of the American Society for the Control of Cancer, of which it is the local representative, and should avail itself of all the facilities the parent society has to offer. It should furnish the State Medical Society of Wisconsin and the State Health Department with educational material from the parent society and should keep its Field Representative, responsible for the work in that territory, fully advised of its activities.

Wisconsin Program as Adopted by Council of State Medical Society of Wisconsin

To the House of Delegates:

The plans of this committee, which have been maturing during the last two and a half years, are now beginning to materialize. Previous reports to the House have outlined in detail the activity planned.

The report of the survey conducted by the American Society for the Control of Cancer has been accepted by the Council and will be published soon in one issue of the JOURNAL. This report brings out some very important facts concerning the facilities in the State for the diagnosis and treatment of cancer. It also shows how cancer has increased in this State during the last two decades.

Cancer has become a public problem in almost every country in the world. Many European countries have recognized the importance of cancer control and the governments have taken over the diagnosis and treatment of these cases in centralized, government controlled hospitals. The necessity for this governmental activity has resulted from the inadequacy of private institutions to finance the purchase of the expensive equipment needed or to secure a staff with sufficient training and skill to properly carry out the procedures involved in modern methods of diagnosing and treating cancer. Your committee, knowing these facts, thought it important to get the facts about the situation in Wisconsin.

There are in the State one hundred and seventeen (117) hospitals receiving so-called private or pay cases. It was obviously impossible and indeed unnecessary to investigate each one of these hospitals as to its method of handling cancer cases. The report is based upon a survey of forty-nine (49) of the larger hospitals located in the large centers of population.

After studying this report, your committee made some definite recommendations to the Council; briefly these recommendations revolved around the apparent necessity of stimulating an interest within the profession in the control of cancer and the necessity for the profession to make some organized efforts to satisfy some of the deficiencies which now exist.

This point is illustrated in the facilities now existing for the microscopic study of tissue, fresh frozen at the time of operation and later paraffin sections. The report indicates that out of the forty-nine (49) hospitals included in the survey there were eight (8) without any laboratory equipment for the study of tissues and six (6) with the apparatus but without the services of a pathologist and in a majority of the hospitals the laboratory is run by a technician. The number of hospitals either without laboratory equipment (8) or without a pathologist (6) is thirty percent (30%) of the hospitals included in the survey. When one recognizes that these forty-nine (49) hospitals represent the largest and best in the State and that thirty percent (30%) are without pathologists, the importance of the job undertaken is immediately obvious.

The Council, therefore, at the January meeting accepted the recommendation that a permanent cancer committee be appointed, one from each Councilor District, and instructed the President, Doctor Fiedler, to appoint the committee and to instruct the committee to report back to the Council its suggestions concerning the rest of the proposals growing out of the survey. The permanent committee appointed by Doctor Fiedler was made up of the following members:

Dr. H. M. Stang, Eau Claire
Dr. Herman Wolf, La Crosse
Dr. F. W. Pope, Racine
Dr. F. Eigenberger, Sheboygan
Dr. F. Gregory Connell, Oshkosh
Dr. W. E. Ground, Superior
Dr. Paul Doege, Marshfield
Dr. S. J. Seeger, Milwaukee
Dr. G. R. Duer, Marinette
Dr. J. F. Wilkinson, Oconomowoc
Dr. E. H. Spiegelberg, Boscobel
Dr. W. D. Stovall, Madison, (Chairman).

The recommendations for the consideration of this committee can probably be better comprehended by the introduction of the report to the Council by the old committee.

"1. The establishment of a permanent Cancer Committee for the State Society, a majority of the membership never changing in one year. It is suggested that this Committee be composed of at least one member from each councilor district and, when feasible, that the chairman be the State Chairman for the American Association for the Control of Cancer.

"2. The organization of a lay auxiliary committee to work with the State Society Committee.

"3. Provide for permanent Cancer Committees for each of the component County Societies, a majority of whose membership shall not expire in any one year.

"4. Authorize the development of a record system for hospitals receiving cancer patients.

"5. Provide for a central tumor registry where tumors removed in various hospitals can be sent for record and filing. These tumors must be accompanied by clinical histories, descriptions of operations, findings at operation and other pertinent matter which the Committee may deem necessary. In order for a hospital to join the tumor registery it will be necessary to provide itself with a record system worked out by the Committee and to be able to supplement this record by a yearly follow-up on each case. The follow-up must be the designated duty of some hospital employee and will be carried out by mailing to these patients or their relative a form letter requesting the information desired.

"6. Authorize a meeting at least twice a year of the interested staff members of the hospital belonging to the tumor registry, the meeting to be called by the Chairman of the Cancer Committee.

"7. Provide that the records and tissues on file in the registry be open at all times to members of the profession who wish to use them for study.

"8. Discuss with the State Board of Health the advisability of making cancer a reportable disease.

"9. Initiate a professional and lay educational program through the cooperation of the agencies and along the lines suggested in the report of the American Society for the Control of Cancer.

"10. Authorize the publication of the report in one issue of the State Medical Journal.

"11. Authorize the drafting of a set of resolutions expressing the thanks and appreciation of the Council to the American Association for the Control of Cancer and Dr. Rector for the survey."

The new committee recommended to the Council the adoption of this report. The Council accepted this recommendation at its April meeting.

The present cancer committee is therefore made up as above described and is busy at the present time with plans to put into operation the recommendations contained in the report.

In addition your committee working with the program committee succeeded in securing a prominent place on the program for cancer at the State meeting last year and also with the cooperation of the dentists and Woman's Club secured large audiences for Doctor Bloodgood, who spoke on The Control of Cancer to the Woman's Club and held a clinic on The Diagnosis of Tumors of the Jaw for the dentists. We also secured the Canti film and had it running during the forenoon and afternoon on each day of the meeting. This year the program committee has also allowed us a generous place on the program.

Respectfully,
W. D. STOVALL, *Chairman,*
For the Cancer Committee.

Autopsies; Legal Questions Involved in Obtaining Authorizations

By HERBERT E. WHIPPLE, Counselor
Madison

The Supreme Court of Wisconsin has held that an illegal autopsy gives rise to an action for damages. We have recently received numerous inquiries on the subject, and our attention has also been called to several instances where damages were alleged. The subject should be of widespread interest to the medical profession.

While a general rule may be stated as to who may authorize autopsies, which will be a safe and sure guide in probably a large majority of cases, yet the rule is not a hard and fast one and is frequently difficult of application. The rule is: An autopsy may be consented to by the person or persons who have the right of custody and burial of the body.

"In normal conditions of human relationship," the Supreme Court has said, "common consent and custom recognize the right and the duty to rest upon those who bore to the deceased in life the closest personal intimacy of acknowledged and lawful relationship. * * * We agree with the great weight of authority that foremost and closest in such relationship stands the surviving spouse * * * but in the absence of a surviving spouse, situations become subject to such complications that it probably is not wise, if proper, to attempt to declare general rules beyond the case actually presented." Koerber v. Patek, 123 Wis. 453.

The Koerber case is the only decision of the Wisconsin court which enters into a discussion of the subject. The court recognizes that each case must be decided upon its own facts, but has indicated, in probably as definite language as possible, the guiding lines in the application of the rule. We quote, page 469:

"The remaining question is whether the right of custody and burial, and resulting right of action for violation thereof, are in the plaintiff. As a result of the decisions and discussions above cited, it cannot be doubted that in the United States, where no ecclesiastical establishment, as a part of the government, equipped with executive and judicial powers as weapons, assumes to itself all authority and right over the dead body before burial, and over both the body and its place of sepulture afterwards, there exists in some individual both the duty and the right to provide to a human body that disposition which general welfare requires, with such ceremonies as convention, respect, and religion dictate. While in the case of one who died remote from those of closer affinity the mere relationship of contact may suffice to arouse such duty in absence of statutes giving charge to some public officer, in normal conditions of human relationship common consent and custom recognize the right and the duty to rest upon those who bore to the deceased in life the closest personal intimacy of acknowledged and lawful relationship. This because, while a duty, the preparation and consignment to final resting place of all that remains of a departed relative is recognized among all civilized peoples as a privilege to continue so far beyond the limit of life that personal service, tenderness, and respect which normally characterized the pre-existing relations. Fiction it may be, but none the less actual,

(Continued on page 662)

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EDITORIALS

KARL W. DOEGE

SOME twenty years ago on my homeward journey from a clinical trip to New York City, I entered into a casual conversation with the quiet, unobtrusive, gentlemanly occupant of the chair next mine in the observation car. I was at once intrigued by the carefully restrained, yet forceful way in which he expressed his opinions in a voice with a slightly foreign accent. When the conversation developed the fact that we were both physicians and residents of Wisconsin the remainder of the journey became a veritable postgraduate course. Dr. Karl Doege was returning from a European clinical trip, and his observations and first hand knowledge of new procedures in diagnosis and treatment, presented in the eager language of the zealous seeker and sharer of medical knowledge, made a deep and lasting impression on me.

Knowing of Marshfield only as a town somewhere in the northern part of the state, I could not but wonder at the word picture he painted of the future he envisioned there of an ever better type of service for his patients. Only a small town doctor but full of enthusiasm and love for his profession, imbued with the idealism of the true physician, self-sacrificing to a fault for others yet mercilessly driving himself through study, research and travel to attain an ever higher grade of professional attainment for the benefit of his patients. This first impression remained unimpaired throughout the ensuing years of professional contact and friendship. If we should get out of life what we put into it, surely it is fitting that Karl Doege came in the fulness of time to garner the fruits of years of that type of unremitting labor and ideal endeavor so characteristic of men who despise mediocrity and always strive for the best.

Believing as he did that the greatest achievement of the true physician is the art of correct diagnosis, he became so favorably impressed with the idea of group cooperation methods in this field that he planned to procure in so far as lay in his power this type of service for his patients. By association with similar minded colleagues, he was able not only to accomplish this but also, and of even greater import as an index to his character, he steadily advanced in the esteem, admiration, respect and love not only of his patients and colleagues but of his brother practitioners as well. Accorded well merited recognition not only in his home state but in many others for his sterling character and professional ability, gained through personal contact and his contributions to medical literature, he leaves an enviable record which will long serve as a stimulating influence to others.

Karl Doege, through ever recurring personal sacrifice and compromise, remained

true to his ideal of a constructive, enduring, organized type of medical service which would continue to function after he passed on. What greater merit can any practitioner attain in metropolitan center or elsewhere than to leave such a record as his of a well spent professional life? Good and faithful physician, ideal citizen, devoted husband and father, steadfast friend—hail and farewell. R. H. J.

THE HEART IN ANEMIA

THE common clinical association of cardiac enlargement and murmurs, with the more advanced degrees of anemia, has recently been viewed by Ball*. In severe anemic states inadequate nutrition of the myocardium lowers its tone and frequently produces cardiac enlargement which clinically and by roentgenological study cannot be differentiated from that produced by organic valvular disease. With relaxation of the cardiac musculature, the valve orifices may become incompetent, thus producing the murmurs so commonly heard under these conditions. Such cardiac findings make it difficult to exclude organic valvular disease until the cause of the anemia is eliminated and the blood has returned to normal. J. H.

COLLAPSE THERAPY FOR PULMONARY TUBERCULOSIS

LAWRASON BROWN divides the modern era of the treatment of tuberculosis into three periods. They are: the sanatorium, the x-ray, and the surgical. The first period begins about 1850 when Boddington in England prescribed rest, good food and fresh air, as directed by the attending physician, as the primary requisites to successful treatment. Brehmer and Dettweiler in Germany, and Trudeau in America, instituted sanatorium treatment based on similar principles. This period, in which reliance was placed primarily on rest, nourishing food and fresh air, extended to about 1905 when the x-ray began to be used. Much was learned of the nature of the disease during the next twenty-five years by this manner of study. Phthisiologists observed the futility of attempting a diagnosis of tuberculosis by physical examination alone. They observed, further, the high death rates in cases of persistent cavities, the different types of spread and healing of the disease, the difficulty of determining the patient's progress by only physical examination of the lungs, and the reaction to the first infection as it occurs in children.

The period of surgery followed largely as a result of x-ray study and dates from about 1930 when collapse therapy was instituted to a greater degree at the leading tuberculosis centers. If present results point correctly, all early cases not doing well after six to eight weeks of bed rest should be candidates for collapse therapy; i. e., pneumothorax, phrenic neurectomy, pneumolysis or thoracoplasty. Even in more advanced cases phthisiologists estimate that from 20% to 40% of all cases would be benefited by some form of surgical treatment.

In too many cases bed rest alone is not sufficient to bring about an improvement in the tuberculous lesion, and in these cases offensive treatment by collapse therapy should be instituted. The danger of a persistent cavity is emphasized by Packard's series of 154 cases with a 70% mortality at the end of five years. It is obvious that the collapse of the cavity, which serves as an incubator for the tubercle bacillus and therefore a constant menace, is of paramount importance. When pneumothorax, pneumolysis, and phrenicectomy fail, thoracoplasty should be done by a competent chest surgeon.

Watching the disease take its course in cases where rest treatment alone is not effective is not enough. Time appears to be proving that collapse therapy has a larger place in the treatment of tuberculosis than we now believe, and that in the early case it may act as a specific. R. H. S.

ANNUAL MEETING PROGRAM

See page 647 for program of the September meeting in Milwaukee.

* American Heart Journal, 6:447–588 (April) 1932

THE PRESIDENT'S PAGE

THE ANNUAL SESSION

MEDICAL associations probably found their origin in the Hippocratean school and are more or less founded on the oath which this "father of medicine" enunciated for his students. That oath contains two fundamental propositions. The first that medical knowledge, since it is knowledge to be employed in human welfare, shall be shared by all members of the profession, and to the everlasting credit of medical men let it be said that no true follower of Aesculapeus has ever failed to impart to his colleagues any discovery which he has made or any knowledge which he has acquired which could be used to alleviate human suffering or prolong human life. The second proposition of the oath recognizes the social and professional obligations involved in the practice of medicine and lays down the rules of ethics in the relation of physician to physician, and defines the obligation which the physician owes to his patients and to the social body. While there have been vast changes in the social body, the general rules as laid down by Hippocrates still hold fundamentally for all these relations, and would accomplish their purpose if we could secure general acceptance and universal practice of the oath.

The medical societies existing today may be considered as of two classes—those which are concerned exclusively with dissemination of medical knowledge, more specific and scientific in their program, and those which are more particularly concerned with ethics and the social obligations of medical practice. In America the official organizations—the American Medical Association with its constituent State Medical Societies and component County units—are concerned with both of these purposes. They offer a scientific program but at the same time their more important functions appertain to the relation of the physician to the social body.

From this it follows that every physician interested in the progress of his own knowledge and work, in the welfare of his profession, and with a social consciousness under the stimulus of which he desires his profession to function properly in the body politic, should affiliate himself with these organizations. Nor is it quite enough simply to maintain membership, but most important that he should attend the meetings of the Society to give and receive medical knowledge, to associate with his colleagues to the end of better professional understanding, and to contribute of his time and thought to the end of securing a more harmonious and efficient adjustment between the profession and the public.

The program prepared this year by the very able Scientific Committee, has such a diversity of subject matter, such wealth of ability in its personnel, that no practitioner in this State can fail to find so much that is of special interest to him that he can afford to miss the session. The demand for service from doctors at the present time is not so heavy but that with a little planning and the will to do so, he can attend at least some of the sessions. I trust too, that the social interest of Wisconsin physicians is sufficient to induce them to attend the meetings of the House of Delegates where they will, of course, be most welcome, and where if they so desire, they may participate in the discussions.

Let every member of the State Society plan now to attend this annual meeting and come prepared to give and to receive of the good things which will be provided. If this is done we shall have increased our knowledge, shall be better able to serve our patients, shall better appreciate our medical social needs and moreover we shall make the 1932 session the best in the history of the State Medical Society.

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Langlade	C. E. Zellmer, Antigo	J. C. Wright, Antigo.
Lincoln	F. L. Kelley, Merrill	W. H. Bayer, Merrill.
Manitowoc	C. H. Barnstein, Newton	E. C. Cary, Reedsville.
Marathon	Joseph F. Smith, Wausau	Verne E. Eastman, Wausau.
Marinette-Florence	T. J. Redelings, Marinette	C. H. Boren, Marinette.
Milwaukee	P. M. Currer, Milwaukee	Theo. Wiprud, Ex. Sec'y, Milw.
Monroe	A. E. Winter, Tomah	H. H. Williams, Sparta.
Oconto	R. J. Goggins, Oconto Falls	G. W. Krahn, Oconto Falls.
Oneida-Forest-Vilas	C. D. Packard, Rhinelander	I. E. Schick, Rhinelander.
Outagamie	E. F. Mielke, Appleton	R. V. Landis, Appleton.
Pierce-St. Croix	H. P. Conway, Spring Valley	A. E. McMahon, Glenwood City
Polk	L. O. Simenstad, Osceola	Geo. B. Larson, Frederic.
Portage	F. A. Marrs, Stevens Point	H. P. Benn, Stevens Point.
Price-Taylor	F. W. Mitchell, Medford	G. L. Baker, Westby.
Racine	C. O. Schaefer, Racine	Susan Jones, Racine.
Richland	W. C. Edwards, Richland Center	G. Benson, Richland Center.
Rock	G. S. Metcalf, Janesville	E. C. Hartman, Janesville.
Sauk	Roger Cahoon, Baraboo	A. C. Edwards, Baraboo.
Shawano	C. E. Stubenvoll, Shawano	L. W. Peterson, Shawano.
Sheboygan	H. F. Deicher, Plymouth	A. C. Radloff, Plymouth.
Trempealeau-Jackson-Buffalo	R. L. Alvarez, Galesville	R. L. MacCornack, Whitehall.
Vernon	W. M. Trowbridge, Viroqua	Wm. H. Remer, Chaseburg.
Walworth	S. G. Meany, East Troy	V. S. Downs, Lake Geneva.
Washington-Ozaukee	O. J. Hurth, Cedarburg	P. M. Kauth, West Bend.
Waukesha	J. C. Hassall, Oconomowoc	J. F. Wilkinson, Oconomowoc.
Waupaca	R. K. Irvine, Manawa	F. J. Pfeifer, New London.
Winnebago	G. E. Forkin, Menasha	M. C. Haines, Oshkosh.
Wood	F. X. Pomainville, Wisconsin Rapids	W. G. Sexton, Marshfield.

SOCIETY PROCEEDINGS

POLK

The Polk County Medical Society has just completed a fracture short course covering the following subjects: Fractures of Shoulder and Arm—Dr. Campbell, Minneapolis; Fractures of Skull, Spine and Hip, Dr. Evans, Minneapolis; Fractures of Wrist and Ankle by Drs. Colvin and Hauser, St. Paul. Dr. R. G. Dunn, Minneapolis, gave a discussion of the "Industrial Aspects of Fractures." Dr. M. O. Henry of Minneapolis gave a discussion of the "Boehler Method" of the treatment of fractures. We were indeed fortunate to have the opportunity of seeing the "Boehler Movies", showing the procedure used by Dr. Boehler.

The Polk County Medical Society, together with the Dental Society are preparing for the final execution of a plan to examine between 6,500 and 7,000 school children when school opens this fall. The examination for this first year will be devoted to the teeth, eyes, ears, nose and throat. We expect the examinations to take the members about two weeks. The examination will be free to the parents and voluntary. The physicians and the dentists in the county have offered to do this work free. G. B. L.

TREMPEALEAU-JACKSON-BUFFALO

On the 9th of June the Trempealeau–Jackson–Buffalo County Medical Society met at Fountain City. Dr. V. S. Counsellor of the Mayo Clinic presented a paper on "The Surgical Significance of the Muscles and Fascia of the Perineum." Both motion pictures and slides were used.

Judge J. C. Gaveny of Trempealeau County and Judge Frank Johnson of Jackson County were the principal speakers at the midsummer meeting held at Whitehall, August 11th. "The Relationship of the County Judge to the Medical Profession" was the subject of each speaker. The meetings were both well attended. The following were admitted to membership: Dr. Irwin Krohn, Black River Falls; Dr. Robert Krohn, Black River Falls; Dr. M. C. Crane, Taylor; Dr. John A. Larson; Alma; and Dr. F. T. Younger of Galesville.

R. L. M.

VERNON

The Vernon County Medical Society met at the Hansberry Hospital at Hillsboro on August 3rd for a social and business meeting.

The morning program which opened at ten o'clock was devoted to a business meeting and a talk by Dr. Spencer D. Beebe, Sparta, councilor of the seventh district. This was followed by a dinner at twelve-thirty served in the hospital dining room.

At one-thirty, Dr. E. F. Schneiders of Madison gave a lecture on obstetrics, illustrated with lantern slides, and was followed by Dr. Walter Jones of La Crosse who spoke on fractures. Other speakers on the program were Drs. W. M. Trowbridge, of Viroqua, J. S. and P. H. Hansberry of Hillsboro. A vote of thanks was given the Doctors Hansberry for their hospitality.

WAUPACA

The Waupaca County Medical Society held its regular meeting at Pines Inn summer resort on McCrossen lake on August 5th. It was a joint meeting with the dentists of Waupaca County. Dr. M. N. Federspiel of Milwaukee was the speaker of the evening.

FIFTH COUNCILOR DISTRICT

The annual meeting of the Fifth Councilor District was held at Kiel on Thursday afternoon and evening, July 28th.

The afternoon program which was held in the Presbyterian church auditorium consisted of the following addresses:

"Some Types of Colitis, Their Diagnosis and Management" by P. W. Brown, M. D., of the Mayo Clinic, Rochester, Minn.

"Unhappy Results in the Treatment of Fractures" by Kellogg Speed, M. D., clinical professor of surgery, Rush Medical College, Chicago.

"Uses and Application of Plaster of Paris," by Herman C. Schumm, M. D., Milwaukee.

During the afternoon, Mrs. D. F. Nauth was hostess to the wives of the physicians at a lawn bridge party at her home.

At six-thirty o'clock, the physicians and their wives, together with the Kiel Chamber of Commerce, enjoyed a dinner at the city hall auditorium.

Dr. Otho A. Fiedler, president of the State Society, was the first speaker of the evening, which was followed by a brief talk by Mrs. D. F. Nauth, president of the Woman's Auxiliary of the American Legion.

Dr. W. A. Evans of the Chicago Tribune, speaking on the subject of "What's Happening to Doctors" gave fullsome praise to the officers of the State Medical Society of Wisconsin for their recent survey on the distribution of medical services in the state. Dr. Evans declared that only through such efforts as these and a united profession could direction be given to the forces of change which are current in the world today.

Following his address, Dr. F. A. Nause of Sheboygan was elected president for the succeeding district meeting and Dr. A. C. Radloff of Plymouth was re-elected secretary.

The evening's program was followed by dancing.

NEWS ITEMS AND PERSONALS

Dr. and Mrs. James P. Dean and family spent two weeks in July motoring through the west and visiting at the Black Hills and Yellowstone Park.

—△—

Dr. A. W. Rogers, and Dr. Francis Wilkinson, both of Oconomowoc, accompanied by Mr. Thomas Spence of Milwaukee spent the first two weeks of August at Rainy River, Ontario, Canada.

—△—

The International Assembly of the Interstate Postgraduate Medical Association of North America will be held in the Murat Theatre and Shrine Temple, Indianapolis, October 24 to 28, 1932. Many distinguished teachers and clinicians will appear on the program. A major list of the names of the contributors to the program, with other information will be published in the October issue of the Journal. All members of this state are cordially invited to attend.

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Dr. James D. Glynn formerly of De Soto, Illinois, has taken over the practice of Dr. E. H. Lechtenberg of Potosi, who moved to Evansville.

—△—

Dr. H. J. Schilling of Platteville has leased the Buck Hospital which was operated for many years by the late Dr. G. C. Buck. Mrs. Hilda Buck, widow of Dr. Buck, will supervise the hospital.

—△—

Dr. Philip H. Becker, formerly of Ottawa, Illinois, a graduate of Marquette University School of Medicine in 1931, became assistant to Dr. J. F. Bennett of Burlington on July 12th.

—△—

Drs. Gunnar and Rolf Quisling of Madison who were recently granted their Wisconsin license, sailed from New York the latter part of July for an indefinite stay abroad. They will study in Berlin and Vienna and will visit clinics in all the principal countries.

—△—

Dr. and Mrs. Kenneth F. Prefontaine of Slinger and their little son figured in an automobile accident the latter part of July when their coupe was struck by another car as they were on their way to Green Bay. Mrs. Prefontaine and the little boy received injuries when they were thrown against the windshield and were taken immediately to a Fond du Lac hospital where they recovered sufficiently to be removed to their home the following day.

—△—

Dr. Earl C. Quackenbush, formerly of Milwaukee, moved to 196½ Main street, Menasha, on July 15th.

—△—

Dr. and Mrs. John T. Morrison, formerly of Madison, visited at the home of Mrs. Morrison's parents, Dean and Mrs. Scott Goodnight, Madison, in July.

Dr. and Mrs. W. A. Ford and sons of Sheboygan returned home the latter part of July from Camp American Legion at Tomahawk, where Dr. Ford was camp physician.

—△—

Dr. Norman Thomas, a graduate of the University of Wisconsin Medical School in 1931, has opened an office at 520 S. Park Street, Madison.

—△—

Dr. V. F. Marshall, Appleton, spoke on "The Romance of Surgery" before a noon meeting of the Kiwanis Club of Appleton.

—△—

Dr. K. A. Swartz of Waupun was named lieutenant governor of Wisconsin–Upper Michigan district of the Kiwanis club at the state convention held in Madison in August.

—△—

Dr. and Mrs. Walter W. Stebbins, accompanied by their daughter and son-in-law, left on August 5th for a three weeks' tour of Mexico and the Grand Canyon.

—△—

At a meeting of physicians of Reedsburg on August 5th, the following members of the staff of the Municipal hospital were elected: President, Dr. F. A. Fike, of Reedsburg; Vice-President, Dr. R. B. Montgomery of La Valle, and Dr. J. D. Walsh, Reedsburg, secretary and treasurer.

—△—

Automobile accidents in Wisconsin during the first six months this year caused 282 deaths, compared with 316 for the corresponding period in 1931, according to a statement by the State Board of Health.

Deaths from collisions of automobiles with railroad trains totaled 37 during the first half of the year, compared with 20 for the similar period last year.

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Dr. R. C. Hartman of Janesville, with a score of 70, won the Janesville golf sweepstake held at the Country club in August.

—△—

Dr. L. E. Dockry of Kewaunee talked on "Skin Diseases of the Face" before a meeting of the Door–Kewaunee County Barbers' Association held at Kewaunee in July.

—△—

Dr. Oscar W. Friske, formerly of Wauseon, Ohio, has purchased the practice of the late Dr. H. C. Maurer of Beloit.

—△—

Dr. H. L. Baxter, a graduate of University of Colorado School of Medicine in 1931, has opened an office at 412 High Street, Neenah. Dr. Baxter

served internship in the Swedish hospital at Seattle, Wash.

—△—

Dr. and Mrs. LeRoy Abbott of Wilton have recovered from injuries received when their car collided with another, due to a cloud of dust.

—△—

Dr. F. J. Pomainville of Wisconsin Rapids was the principal speaker at a noon meeting of the Rotary Club of that city. Dr. Pomainville spoke on the progress made in the medical and surgical profession in recent years.

—△—

Dr. and Mrs. G. G. Stebbins, Madison, accompanied by Mrs. Stebbins' mother, spent five weeks at Trout Lake where Dr. Stebbins was camp physician for the boys at Red Arrow camp.

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A total of seven cases of poliomyelitis were reported in Wisconsin in July, compared with 36 in July, 1931, according to an announcement by the State Board of Health.

—△—

Dr. and Mrs. T. J. Snodgrass and son of Janesville enjoyed an outing at their camp near Superior.

—△—

Dr. Frank G. Treskow, a graduate of the University of Wisconsin Medical School in 1931, has opened an office in the village of Helenville.

—△—

Dr. and Mrs. E. R. Schmidt, and family, Madison, spent their vacation on the Brule.

—△—

Visitors at the offices of the State Medical Society during August included Dr. Helen Binnie, Kenosha; Mr. Walter A. Drews, Milwaukee, investigator for the State Board of Health; Dr. James C. Sargent, Milwaukee and Mr. Theodore Wiprud, executive secretary of the Medical Society of Milwaukee County.

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MILWAUKEE

Dr. Ralph W. Garens left Milwaukee on July the 19th for Camp Highlands, in Vilas County, Wisconsin, where he has accepted the position of medical advisor. He expects to be at Camp for five or six weeks.

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Dr. and Mrs. L. G. A. Schuenzel and their son have enjoyed a tour of the west. They visited the Yellowstone National Park, California, and Washington before their return to Milwaukee on August first.

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Dr. R. C. Schodron, together with a party of friends, left the city the middle of July for a two weeks' vacation at Niagara Falls.

—△—

Drs. N. Warren Bourne, W. L. MacKedon, and E. A. Brzezinski returned to Milwaukee the first part of August from Camp Douglas, Wisconsin.

Dr. and Mrs. T. A. Judge and children left Milwaukee about the middle of July for a two weeks' outing at Elkhart Lake.

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Dr. and Mrs. Chester C. Schneider and family are spending the summer at the Lakeside Hotel, Pewaukee Lake, Wisconsin.

—△—

Dr. and Mrs Charles Zimmerman have been entertaining their daughter, Mrs. Prescott Carter, for several months. Mrs. Carter left about the middle of July for New York, from where she will sail for her home in Antwerp, Belgium.

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The Medical Society of Milwaukee County is again co-operating with the Milwaukee Health Department in the annual diphtheria prevention campaign. Every effort is being put forth to immunize all children who come under the care of private practitioners..

—△—

The marriage of Miss Gertrude Zivnuska, daughter of Dr. and Mrs. J. F. Zivnuska, to Mr. E. Walter Rickmeyer of Chicago took place on July 9th in the Marquette University Chapel.

—△—

A committee consisting of Drs. P. M. Currer, J. C. Sargent, and R. P. Sproule considered with Mr. Max Raskin, city attorney, at a meeting held on July 11 the appointment of a panel to do compensation work in Milwaukee.

This meeting was the result of the action taken by the board of directors of The Medical Society of Milwaukee County at its meeting on June 28th, when the following resolution was passed:

"WHEREAS, The board of directors of The Medical Society of Milwaukee County have been informed that the city of Milwaukee contemplates a change in its panel of physicians to render medical service to its employees under the Workmen's Compensation Act, and

"WHEREAS, The medical profession, as taxpayers and practicing physicians of Milwaukee, are vitally interested in such an arrangement, and

"WHEREAS, The limiting of the panel to a few appointees is not in the public interest and is undesirable because it denies to the patient the right to a reasonable choice of physician,

"*Be it therefore resolved*, That the board of directors of The Medical Society of Milwaukee County recommend to the City of Milwaukee that the panel, —if one is contemplated,—embrace all physicians who are members in good standing of The Medical Society of Milwaukee County willing and able to participate in this type of work, because it is the belief of the board of directors that better service to the public and a more equitable arrangement among physicians will result."

Mr. Raskin stated there would be no change in the panel at this time and that he did not favor the enlargement of the panel to include a large percentage of members of the Society. He promised,

however, to watch with interest the arrangement agreed upon by the insurance companies and the Society which provides for free choice of physician, with certain limits.

—△—

Upon the request of the Central Council of Social Agencies that the Society be represented on the Council, the board of directors of The Medical Society of Milwaukee County, at their meeting on June 28th, recommended that Mr. Theodore Wiprud, executive secretary of the Society, be elected a member of the Council's Board of Directors.

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The Fifth Annual Golf Tournament, sponsored by the Milwaukee County Physicians' Golf Association and The Medical Society of Milwaukee County, was held at the Waukesha Country Club on July 21st.

The Association and the Society were guests of Mr. Howard Greene, manager of the Brookhill Farms.

Following a trip through the farms luncheon was served. Approximately fifty took advantage of the opportunity to inspect the Brookhill plant.

The tournament got under way at 1:30 P. M. with 101 physicians registered. It was the largest tournament which the Association and the Society have sponsored.

At the close of the tournament a dinner was given by Mr. Greene at the Pleasant Valley Farm, following which the business meeting of the Association was held and prizes awarded as follows:

	Score
1st Low Gross, won by Dr. S. R. Mitchell	78
1st Low Net, won by Dr. B. E. Urdan	65
2nd Low Gross, won by Dr. Mark A. Bach	81
2nd Low Net, won by Dr. R. J. M. Russell	65
3rd Low Gross, won by Dr. Hyman Mendeloff	84
3rd Low Net, won by Dr. J. T. Klein	70
4th Low Gross, won by Dr. Wm. A. Ryan	86
4th Low Net, won by Dr. Frank E. Drew	72
5th Low Gross, won by Dr. E. W. Miller	86
5th Low Net, won by Dr. J. C. Griffith	72
6th Low Net, won by Dr. M. J. Reuter	73
7th Low Net, won by Dr. J. Garland	73
8th Low Net, won by Dr. Leon Guerin	73
9th Low Net, won by Dr. C. Dunn	75
10th Low Net, won by Dr. C. C. Reinke	76
11th Low Net, won by Dr. J. J. McGovern	76
12th Low Net, won by Dr. F. McCormick	77
13th Low Net, won by Dr. A. L. Curtin	77
14th Low Net, won by Dr. E. L. Bernhard	78
15th Low Net, won by Dr. Conde F. Conroy	79
16th Low Net, won by Dr. A. J. Weber	79
17th Low Net, won by Dr. Al. G. Schutte	80
18th Low Net, won by Dr. J. A. Jenner	80
19th Low Net, won by Dr. A. V. DeNeveu	80
20th Low Net, won by H. O. Zurheide	80
21st Low Net, won by Dr. R. E. Fitzgerald	81
22nd Low Net, won by Dr. N. E. McBeath	81
23rd Low Net, won by Dr. H. B. Podlasky	81

Miscellaneous prizes were awarded for the least number of strokes on hole #7; for the most strokes on hole #4; to the homeliest man; the best looking man; the one with the highest number of strokes; the hungriest man; the best natured man, and the crabbiest man.

Dr. S. R. Mitchell, this year's champion, was unanimously elected president of the Golf Association, and Dr. Mark A. Bach, secretary and treasurer.

—△—

The first meeting of the Society's newly appointed committee on insurance was held at the University Club on July twelfth. The committee met in joint session with the committee of insurance company representatives.

It was agreed at this meeting that all difficulties arising between the medical profession and insurance companies would be reviewed by these committees upon the request of any insurance company or physician.

It was decided that the physicians of Milwaukee County should be circularized to determine the number of those willing and capable of doing compensation insurance work with a view to enlarging the panels to include these men.

Following a discussion regarding fees, it was agreed by those present that physicians should be compensated by being paid the conventional fee charged the patient in ordinary circumstances.

Members of both committees agreed that there was opportunity for them to render real service to the public, the medical profession, and the insurance companies.

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Dr. and Mrs. John O. Dieterle, who have been abroad since their wedding on June 22nd, returned to Milwaukee early in August.

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Miss Verna Seegers, daughter of Dr. F. W. Seegers, was married to Mr. Ed Gerbic on June the 28th.

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Dr. and Mrs. A. W. Gray returned to Milwaukee on August seventh from Trout Lake where they spent several weeks.

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Dr. and Mrs. F. J. Gaenslen are spending the summer months at their country home at Pewaukee Lake.

—△—

Dr. Harold B. Miner left on July 25th for a motor trip to Canada where he spent several weeks.

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Dr. Carl Henry Davis and family enjoyed a ten day cruise on the Great Lakes during August.

—△—

Dr. and Mrs. A. J. Patek have announced the marriage of their daughter, Charlotte Patek Herzfeld, to Mr. George G. Schneider. Mr. and Mrs. Schneider left immediately following the wedding ceremony for a trip through northern Wisconsin.

—△—

Dr. Francis B. McMahon left in July for a trip to Panama.

Mrs. Josephine Arnold, wife of Dr. F. W. Arnold, passed away at her home, 2160 S. Layton Boulevard, on Monday, July the twenty-fifth, at the age of sixty years.

Mrs. Arnold is survived by her husband, a sister, Miss Katherine Schloegel, and a brother, Andrew Schloegel.

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Dr. G. I. Hogue, Colonel in the Madison Reserve Corps of the United States Army, spent two weeks in July at Fort Sheridan with General Hospital No. 22, of which he is Commanding Officer.

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Office Removals: Drs. Hitz, Gordon, and Sproule from 425 E. Wisconsin Ave. to 208 E. Wisconsin Avenue.

Dr. Norbert F. Dettmann from 531 W. Wisconsin Avenue to 6803 W. Wells Street, Wauwatosa.

Dr. Frank C. Margoles from 1309 W. Vliet Street to 729 N. Thirty-second Street.

Dr. Roy W. Benton, formerly on the medical staff of the A. O. Smith Corporation, is now located in the office of Dr. Paul Brehm, 425 E. Wisconsin Avenue. Dr. Benton has taken over the practice of Dr. Brehm who left on July 1st for South America where he expects to remain for one or two years.

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Dr. A. H. Lahmann, who was confined to his home, several weeks following an attack of scarlet fever, resumed his practice the latter part of July.

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Work on the study of contract and panel practice in Milwaukee County is progressing rapidly, and it is expected that it will be completed before the first of September. A report will be presented before the House of Delegates of the State Medical Society when they meet in Milwaukee in September.

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Dr. and Mrs. Carl W. Eberbach sailed on August eighteenth for a five weeks' stay in Bermuda.

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Dr. S. F. Morgan, formerly of the Mayo Clinic of Rochester, Minnesota, has opened offices at 4019 N. Oakland Avenue. Dr. Morgan specializes in diseases of children.

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Dr. J. W. Smith, who went abroad in January for several months' study in Vienna and Paris, arrived in New York on August 15th. After several weeks' postgraduate study in New York Dr. Smith expects to return to Milwaukee to resume his practice.

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Dr. Louis Dorpat, former health officer of Ironwood, Michigan, has been appointed superintendent of the South View Isolation Hospital, Milwaukee.

Dr. Dorpat is a former resident of Wisconsin, having practiced medicine in Milwaukee County from 1908 to 1916, and having served as Deputy State Health Officer for the northern part of Wisconsin from 1916 to 1924, at which time he was appointed health officer of Ironwood, Michigan, which position he has held until his recent appointment in Milwaukee.

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Dr. E. L. Miloslavich, director of the department of clinical pathology and medical research at St. Mary's Hospital, Milwaukee, returned on August eighth from an extended motor trip in Europe where he visited several institutes of legal medicine and criminology.

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Dr. C. R. Marquardt, former resident physician at the Milwaukee County Hospital, became associated with Dr. James C. Sargent, president-elect of The Medical Society of Milwaukee County, on July 1st, in the practice of urology.

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The nomination of Dr. Stanley J. Seeger as chairman of the local committee on arrangements for the 1933 session of the American Medical Association in Milwaukee was approved by the Society's Board of Directors at their meeting on July the 26th.

At this meeting Dr. J. W. Powers was appointed local chairman for the golf tournament of the American Medical Golf Association, and Dr. J. Gurney Taylor, chairman of the alumni dinners.

Appointments to other committees will be announced at a later date.

BIRTHS

A daughter to Dr. and Mrs. J. A. Murphy, Milwaukee, on June 18th.

Twin sons to Dr. and Mrs. M. B. Byrnes, Milwaukee, on August 1st.

A daughter to Dr. and Mrs. Benjamin Lieberman, Milwaukee, on August 4th.

A son, David Olaf, to Dr. and Mrs. A. T. Smedal, Stoughton, July 20th at Madison.

A son to Dr. and Mrs. M. J. Reuter, Milwaukee, on August 13th.

MARRIAGES

Dr. John O. Dieterle, treasurer of the Medical Society of Milwaukee County, and Miss Charlotte Logemann, daughter of Mr. and Mrs. A. G. Logemann, on June 22nd.

Dr. Raymond A. Toepfer, Milwaukee, and Miss Carla A. Rhode at Milwaukee on August 11th.

Dr. George J. Gumerman, Milwaukee, to Miss Josephine Berdoll, Milwaukee, on August 3rd.

Dr. William L. MacKedon, Milwaukee, to Miss Ethel Margaret Theisen, Milwaukee, at Racine on July 13th.

Dr. Dean Echols, son of Dr. and Mrs. Chester M. Echols, Milwaukee, to Miss Frances Foerster, daughter of Dr. and Mrs. Otto H. Foerster, also of Milwaukee, on September 10th.

Dr. James H. Biller, Milwaukee, to Miss Ida T. Schmerling of Milwaukee.

Dr. George Edward Whalen, Milwaukee, to Miss Rosalie M. Keller, in Milwaukee on August 18th. Dr. and Mrs. Whalen left immediately on a wedding tour through Europe. They expect to spend some time with Mrs. Whalen's mother, Mrs. A. Kadan, in Ulm, Germany, before returning to Milwaukee.

Dr. Alois F. Kustermann, Milwaukee, to Miss Helen M. Schwaller, in Milwaukee on August 18th. Mrs. Kustermann is a registered nurse. Upon finishing her training at St. Joseph's Hospital she became associated with the Visiting Nurse Association. Dr. Kustermann is a member of the staff of the Jermain Clinic.

DEATHS

Dr. Clara L. Normington, Janesville, died on August 15th at her home following a short illness.

Born in Durand, Ill., April 18, 1854, she had lived in Janesville the past 54 years. She was a graduate of the Woman's Hospital Medical College in 1878. Following graduation, she opened an office in Janesville where she remained until her death.

She is survived by two brothers and two sisters.

Dr. Hugh B. Johnson, Tomah, died on August 12th at his home. He had been in ill health for the past three years.

Dr. Johnson was born January 31, 1867, at Fall Creek, Eau Claire County, Wisconsin. He was a graduate of Northwestern University School of Medicine in 1892 and then came to Tomah to become assistant to Dr. Quigg. He remained in Tomah up to the time of his death.

Dr. Johnson was a former member of Monroe County Medical Society, the State Medical Society, and the American Medical Association.

He is survived by his widow and three sons.

Dr. R. C. Blankinship, Madison. As the Journal goes to press we learn of the sudden death from coronary thrombosis of Dr. R. C. Blankinship, professor of internal medicine, University of Wisconsin. Dr. Blankinship died as he was concluding an automobile trip at the home of his brother-in-law in Huntington, West Virginia. The formal notice will appear in the October issue of the Journal.

SOCIETY RECORDS

New Members

John A. Larson, Alma.
Irwin Krohn, Black River Falls.
Michael Kasak, Box #1, Wauwatosa.
Peter Bell, Winnebago.

Changes in Address

Earl C. Quackenbush, Milwaukee to 196½ Main St., Menasha.

L. E. Rauchschwalbe, Evansville to 2653 No. 10th St., Milwaukee.

Mead Burke, Kendall to 110 No. Spooner St., Madison.

Myra T. Burke, Kendall to 110 No. Spooner St., Madison.

George Klinger, Neenah to 2734 No. 50th St., Milwaukee.

S. M. Turkeltaub, Milwaukee to 5th Avenue & 100th St., New York City.

E. H. Lechtenberg, Potosi to Evansville.

R. O. Bassuener, Sheboygan to Sheboygan Falls, R. #2.

THE WOMAN'S AUXILIARY

Mrs. Orvil O'Neal, Ripon, Editor

ENTERTAINMENT FOR LADIES

Extensive plans for the entertainment of all visiting ladies and members of the Auxiliary at the Milwaukee meeting of the State Medical Society, Sept. 13–16, were announced in late August by Mrs. Henry Gramling, President of the State Auxiliary; Mrs. E. C. Carey, Program Chairman and Mrs. L. M. Warfield, Chairman of Entertainment. The visiting ladies, whether members or not of the State Auxiliary, are particularly urged to attend the program arranged in their behalf.

Among those who will speak at business sessions of the Auxiliary are Mrs. Walter Jackson Freeman of Philadelphia, President of the National Auxiliary; Dr. William A. Evans, Editor of Health Department, Chicago Tribune; Dr. Otho Fiedler, Sheboygan, President and Mr. George Crownhart, Secretary of the State Medical Society. The detailed program for the entertainment of the ladies and meetings of the Auxiliary follows:

AUXILIARY PROGRAM

Tuesday, September 13th

6:00 P. M. Executive Board Dinner, University Club.

Wednesday, September 14th

9:30 A. M. Breakfast at Colony Inn Tavern—80¢.
Speakers: Mrs. Walter Jackson Freeman, Philadelphia, National President of the Woman's Auxiliary. Dr. Otho Fiedler, President, State Medical Society of Wisconsin. Dr. Louis F. Jermain, Milwaukee.
Business Meeting.
Golf. North Hills—open to all.

4:00–6:00 P. M. Tea and musicale for visiting ladies at the home of Mrs. Rock Sleyster, Wauwatosa.

Thursday, September 15th

12:00 M. Luncheon and Bridge at the College Woman's Club—85¢.
Speaker: Dr. William A. Evans, "The Job of Being a Doctor's Wife."
Election and installation of officers. Presentation of gavel by Mr. George Crownhart, Secretary of State Medical Society.

7:00 P. M. Annual dinner of the State Medical Society at the Schroeder Hotel.

Friday, September 16th

10:00 A. M. Post-convention board meeting, Parlor B, 4th Floor, Schroeder Hotel.

11:00 A. M. Round Table discussion, Parlor A, 4th Floor, Schroeder Hotel with Mrs. James Blake, National President-Elect, presiding. Mrs. Blake will discuss the reasons for organizing county auxiliaries.

Those who desire to play golf on Wednesday afternoon, September 14th, please make reservations before 9:00 Wednesday morning, September 14th, with Mrs. John F. Blair, 6029 W. Wisconsin Avenue, Wauwatosa, or phone Greenfield 5223. Transportation will be furnished from the Colony Inn.

ONLY occasionally are we privileged to hear or see that which seems to be perfection itself. When we are so fortunate we immediately wish to share our enjoyment with all our friends.

Such is the occasion for reprinting below the "In Memoriam" address of Mrs. Frank W. Cregor of Indianapolis which was presented before our National Meeting at New Orleans last spring.

"The Greeks of classic days attributed especial emotional significance or fanciful characteristics to their modes or scales; for instance, the Dorian mode was considered the true Greek scale, firm, manly, grave, severe, suitable for martial songs; the Hypo-Dorian was mournful; the Lydian, gladdening; the Phrygian, exulting. To this distinctive national trait, I, a musician, turn for the form to use today in my 'In Memoriam' for those members who have preceded us into that mysterious land from whose bourne no traveller ever returns.

"As a priestess of old, figuratively speaking, I tune the strings of my lyre in the Phrygian, the exulting mode, and sing my praises to that altruistic organization which has for one of its cardinal principles the promotion of 'acquaintanceship among physicians' families that fellowship may increase'. Fellowship—fellowship is a word of concord, of harmony; it connotes association, communion, intimacy, joint interest or feeling. Fellowship and its attendant virtue Friendship are in the very foundation of this sisterhood with which I am proud to be affiliated.

"Exult, oh ye members of the Woman's Auxiliary to the American Medical Association, that high above us floats always a banner inscribed 'Fellowship'! Rejoice, that this organization gives us opportunity to meet other women animated by similar desires of Fellowship and Service!

"I exult in many friendships begun under the auspices of this Woman's Auxiliary; I cherish friends in far away states, met first at the annual gatherings of this organization. Frequently, have I heard the expression, 'It is the friendships that we make that repay us.' To quote one of our national presidents, 'God gives us friends that we may have roses in our Decembers.'

"I treasured the friendship of one of my townswomen; a woman of many talents and graces; a woman whom I would not have met, in all probability had it not been for the Auxiliary; placed on a committee together, I learned to know her and her unusual ability in dramatic art; her cooperation was inspiring. I was happy to assist her when she succeeded me as chairman of our Program Committee. She remains a symbol to me—she was the first of our Auxiliary to go.

"I pause—a poignant chord holds me in its spell. Into my song of exultation comes a minor strain; I find myself in the mournful mode, the Hypo-Dorian.

"Mourn ye Daughters of Man that the days for accomplishments are so few; that the years for Friendships are numbered; that Time is fleeting as in youth and strength we say, 'oh, I'll do that later'. The day of parting comes only too soon. Chastened we stand in the presence of Death—words of comfort fall on ears deafened by the sound of the wings of the Dread Messenger; on minds numbed by loss. Death is so inexorable; so silent! Never is Never.

" 'As we long for the touch of a vanished hand,
And the sound of a voice that is stilled.'

"Mourn ye women here assembled for the members who have answered their last roll-call. 'Out of the depths we cry unto Thee, O Lord. Lord hear my voice; let Thine be attentive to the voice of my supplication.'

" 'With the Lord there is mercy; and with Him is plenteous redemption.'

"Mourn, but with faith in Him who is the Resurrection and the Life. In the book of Maccabees is written, 'It is a holy and wholesome thought to pray for the dead that they may be loosed from their sins.'

"Ladies, fellow-members of the Woman's Auxiliary to the American Medical Association, let us remember our dear departed as we bow our heads for a moment of silent prayer.

"Requiescat in pace. Amen."

POLK COUNTY AUXILIARY ORGANIZED

On July twenty-first the members of the Polk County Medical Society and their wives were entertained by Dr. and Mrs. Riegal of St. Croix Falls at their summer home on Deer Lake.

The afternoon was spent in playing golf and bridge and boating. As twilight drew near they were served a most delicious barbecue dinner.

After the dinner the ladies gathered in the large living room and proceeded with the assistance of the Executive Secretary of the State Auxiliary to organize a Woman's Auxiliary to the Polk County Society. The following officers were elected: President, Mrs. J. A. Riegel, St. Croix Falls; Secretary, Mrs. R. G. Arveson, Frederic; Treasurer, Mrs. L. O. Simenstad, Osceola; Press & Publicity Chairman, Mrs. A. N. Nelson, Clear Lake; Hygeia Chairman, Mrs. J. A. Diamond, Frederic.

Over 900 Expected at Ninety-First Anniversary Meeting of State Society at Milwaukee, September 13th-16th; Program Issued

Upwards of 900 members of the State Medical Society of Wisconsin will register next week for the 91st Anniversary Meeting at the Schroeder Hotel in Milwaukee. In a three-day scientific meeting that features guests of national standing, the constant endeavor of the Program Committee has been to provide subjects and presentations will be of the greatest possible practical value.

"The meeting will open formally at eight Wednesday morning, September 14th, with two hours of clinical demonstrations at the Milwaukee hospitals. These demonstrations will be limited to small groups and admittance by reservation that the teaching may be of that intimate character that is not possible in the larger meetings outside of the hospitals", declares Dr. T. L. Squier, Chairman of the Committee on Scientific Work. "The Round Table luncheon conferences for groups of twenty and under are continued this year in response to the great demand for these two hour session group meetings. They will again be held on Thursday, the second day of the meeting."

WILL RUN ON SCHEDULE

As in the past four years, presiding officers will maintain the scheduled times strictly. There will be no changing of speakers from scheduled hours. Each speaker will start promptly at the hour specified and members are assured that there will be not more than five minutes variance from the schedule as published.

Dr. George W. Crile of Cleveland will present the Oration in Surgery and Dr. David Barr of St. Louis will deliver the Oration in Medicine. Dr. Crile's subject is "Denervation of the Adrenal Glands" and Dr. Barr will speak on "The Parathyroid Glands and Their Relation to Calcium Metabolism." Dr. Crile is the founder of the Cleveland Clinic and Professor Emeritus of Surgery at Western Reserve University School of Medicine. Dr. Barr holds the chair of Professor of

Medicine at Washington University School of Medicine at St. Louis.

Other guest speakers for the session include Max Cutler, Director of the Tumor Clinic, Michael Reese Hospital, who will speak on the Clinical and Pathological Aspects of the Cancer Problem; Udo Wile, Professor of Dermatology and Syphilology at the University of Michigan, who will speak on Occult Syphilis—A Neglected Factor in Diagnosis and Treatment; W. W. Duke of Kansas City, recognized as an outstanding authority, who will discuss Allergy; Samuel Amberg, Associate Professor of Pediatrics at the University of Minnesota Graduate School of Medicine, who will discuss Abdominal Conditions in Childhood; Chas. H. Watkins of Rochester, Minnesota, who will speak on Leukopenia and Acute Leukemia; Ellsworth S. Smith, Professor Emeritus of Clinical Medicine at Washington University School of Medicine, who will speak on The Treatment of Heart Disease; E. T. Bell, Professor of Pathology at the University of Minnesota, who will speak on the Etiology and Pathology of Nephritis; and Professor Julius Bauer of Vienna, Austria, who will discuss Constitution in Relation to Disease. Dr. Bauer is a very clear speaker with excellent command of English, so that there need be no fear of difficulty in understanding him. He has an international reputation as an investigator and author, especially in the field of endocrinology and the influence of constitutional traits on disease.

WEDNESDAY, SEPTEMBER 14

8:00–10:00. Hospital clinics and demonstrations. *(Admission by ticket from Secretary only.)*

Children's Hospital. (Limited to 50.)
Wisconsin Avenue at 17th Street.
Case presentations, ward visits, and demonstrations of apparatus and technique.

Columbia Hospital. (Limited to 75.)
3321 N. Maryland Avenue.
Presentation of cases. Clinical and pathological demonstrations.

Milwaukee Hospital. (Limited to 25.)
2200 W. Kilbourn Avenue.
Bronchoscopic clinic.
Dr. John S. Gordon.
Demonstration of urological cases.
Drs. Fletcher and Bourne.

SYNOPSIS OF PROGRAM

Tuesday—Sept. 13th

9:00 A. M.	Practice play, Golf Tournament, Tripoli Country Club.
12:00 M.	Golf Luncheon, Tripoli Country Club.
12:00 M.	Lunch, Committee on Public Policy, Room B, 5th Floor, Schroeder.
1:00 P. M.	Golf Tournament followed by dinner, Tripoli Country Club.
2:00 P. M.	Council Meeting, Room C, 5th Floor, Schroeder Hotel.
5:00 P. M.	Secretaries' Dinner, Pere Marquette Room, Schroeder.
7:00 P. M.	First Session, House of Delegates, Grand Ballroom, Schroeder.

Wednesday—Sept. 14th

7:00 A. M.	Registration Opens, Fifth Floor Schroeder Hotel.
8:00 A. M.	Clinical Demonstrations at Milwaukee Hospitals.
10:20 A. M.	Scientific Sessions, Grand Ballroom, Pere Marquette Room and English Room.
12:00 M.	Alumni Luncheons. See program.
1:30 P. M.	First General Session, Grand Ballroom.
5:30 P. M.	Council Dinner, Room B, 5th Floor.
7:30 P. M.	Second Session, House of Delegates, Grand Ballroom.

Thursday—Sept. 15th

7:00 A. M.	Registration, Fifth Floor.
7:30 A. M.	Last Session, House of Delegates, Loraine Room, Lobby Floor.
8:00 A. M.	Scientific Sessions, Grand Ballroom, Pere Marquette Room and English Room.
12:00 M.	Round Table Conferences. See program.
2:10 P. M.	Second General Session, Grand Ballroom.
7:00 P. M.	Annual Dinner, Informal, Grand Ballroom.

Friday—Sept. 16th

7:00 A. M.	Registration Opens.
8:00 A. M.	Scientific Sessions, Grand Ballroom, Pere Marquette Room and English Room.
10:00 A. M.	Third General Session, Grand Ballroom.
1:40 P. M.	Fourth General Session, Grand Ballroom.
5:30 P. M.	Adjournment.

Ward demonstrations.
Dr. O. R. Lillie.
Carcinoma of the rectum, with report of cases.
Dr. C. A. Evans.

Milwaukee Maternity and General Hospital. (Limited to 50.)
1845 N. 4th Street.
Obstetrical clinic.
Gastro-enterological clinic.

Misericordia Hospital. (Limited to 20.)
2224 W. Juneau Avenue.
Obstetrical clinic—Caesarean section.
Presentation of Cases.
Drs. L. J. Foley, E. Gramling, Wm. A. Ryan, and V. Taugher.

Mount Sinai Hospital. (Limited to 150.)
908 N. 12th Street.
Clinical-pathological conference. Presentation of case histories, clinical data, and pathological findings.

Milwaukee County Hospital. (Limited to 150.)
Wauwatosa.
Clinical—pathological conference.
Dr. Francis D. Murphy and Dr. John Grill.
Orthopedic clinic.
Dr. Herman Schumm.
The Treatment of Acute Empyema.
Dr. Joseph M. King.

St. Mary's Hospital. (Limited to 75.)
2320 N. Lake Drive.
Orthopedic clinic.
Dr. Frederick Mueller.
Surgical clinics—operations.
Dr. W. C. F. Witte.
Dr. Ernest W. Miller.
Presentation of pathological material.
Dr. Edward L. Miloslavich.
Medical clinic.
Dr. Arthur F. Rheineck.

St. Joseph's Hospital. (Limited to 50.)
5000 W. Chambers Street.
Clinics and demonstrations in general surgery, urology, and orthopedic surgery.
Drs. C. Echols, F. A. Stratton, Jas. Sargent, and J. W. Powers.

St. Luke's Hospital (Limited to 40.)
230 W. Madison Street (between 2nd and 3rd streets).
Acute appendicitis.
Dr. Henry J. Gramling.
Treatment of intestinal obstruction.
Dr. E. H. Mensing.
Hematuria.
Dr. W. J. Carson.
Oblique fracture of the femur.
Dr. J. F. Zivnuska.
Treatment of cardiac emergency.
Drs. John Huston and E. L. Tharinger.
Perforation of ventral hernia during pregnancy.
Dr. Stanley L. Krzysko.

SPECIAL GARAGE ACCOMMODATIONS

Special rates for automobiles have been granted members by the Fifth and Michigan Garage, next to the Schroeder Hotel. Rates include "in and out" privileges. Members should ask for this special rate when driving in for the first time.

Mediastinal tumor.
Dr. Joseph Gramling.
Coronary artery diseases.
Dr. W. V. Nelson.

WEDNESDAY, SEPT. 14—10:20–12:00

GRAND BALLROOM

Dr. A. W. Rogers, Presiding

10:20. "Treatment of Chronic Osteomyelitis." Lantern Slides.
Dr. Walter J. Jones, La Crosse.
10:45. "Intussuception."
Dr. L. W. Peterson, Shawano.
11:10. "Anal Fissures." Lantern Slides.
Dr. A. C. Gorder, Milwaukee.
11:35. "The Ambulatory Treatment of Hemorrhoids; Analysis of over twelve hundred cases."
Dr. J. M. Scantleton, Sparta.

PERE MARQUETTE ROOM

Dr. Francis McMahon, Presiding

10:20. "Keeping the Worker Well and Keeping the Practice of Medicine in the Hands of the Medical Profession."
Dr. C. F. Schram, Beloit.
10:45. "Surgical Treatment of Hand Injuries."
Dr. T. S. O'Malley, Milwaukee.
11:10. "Indications and Contraindications for Biopsy in Surgery."
Dr. P. F. Doege, Marshfield.

ENGLISH ROOM

Dr. Claude S. Beebe, Presiding

10:20. "Glioma Retinae (Neuroepithelioma): Report of a Case." Lantern Slides.
Dr. Richard C. Smith, Superior.
10:45. "Orbital Inflammation Secondary to Sinus Infection."
Dr. John B. Hitz, Milwaukee.
11:10. "Otitis Media and the Family Physician."
Dr. John P. Harkins, Madison.
11:35. "Treatment of Nasal Polyps with Radium after Removal."
Dr. Walter A. Ford, Sheboygan.

12:00. ALUMNI LUNCHEONS.
1. Rush --------Pere Marquette Room, 5th Floor
2. Northwestern -------English Room, 5th Floor
3. Michigan ----------Room E, 5th Floor
4. Marquette -------Loraine Room, Lobby Floor

5. Minnesota ----------Room D, 5th Floor
6. Illinois (Chicago P & S)---Room C, 5th Floor
7. Wisconsin ----------Room B, 5th Floor

1:30 P. M. GENERAL SESSION. GRAND BALL ROOM.

1:30 "The Orthopedic Treatment of Infantile Paralysis." Moving Pictures.
Dr. Walter P. Blount, Milwaukee.

1:50. "The Clinical and Pathological Aspects of the Cancer Problem."
Dr. Max Cutler, Chicago.

2:20. "Occult Syphilis: A Neglected Factor in Diagnosis and Treatment."
Dr. Udo Wile, Ann Arbor.

2:50. "End Results of Cholecystectomy: Based on a study of six hundred cases." Lantern Slides.
Dr. Arnold Jackson, Madison.

3:10. "Intestinal Obstruction: Application of Some of the Newer Principles Evolved from Experimental and Clinical Experience."
Dr. Edmund H. Mensing, Milwaukee.

3:30. *Intermission.*

3:40. "Treatment of Burns." Lantern Slides.
Dr. Stanley Seeger, Milwaukee.

4:00 "The Development of Medical Education in the United States."
Dr. C. R. Bardeen, Madison.

4:20. "Oration in Surgery. Denervation of the Adrenal Glands."
Dr. Geo. W. Crile, Cleveland.

7:30. Second Session, House of Delegates, Grand Ballroom.

THURSDAY, SEPTEMBER 15

7:30. Third Session, House of Delegates, Loraine Room.

GRAND BALLROOM

Dr. L. M. Warfield, Presiding

8:00. "The Use of the Colloidal Phase in Urine for Diagnostic Purposes."
Dr. Frederick Eigenberger, Sheboygan.

8:25. "The Physician of Yesterday, Today, and Tomorrow."
Dr. John F. Bennett, Burlington.

8:50. "Treatment of Morphinism."
Dr. Merle Q. Howard, Wauwatosa.

9:15. "Dermatology in General Practice." Lantern Slides.
Dr. L. M. Wieder, Milwaukee.

9:40. *Intermission.*

10:10. "The Electrocardiogram in General Medicine."
Dr. Benjamin J. Birk, Milwaukee.

10:35. "The Importance of Blood Grouping in Clinical and Legal Medicine." Lantern Slides.
Dr. Arthur A. Schaefer, Milwaukee.

11:00. "Will Cretinism Become Endemic in Wisconsin?"
Dr. Charles H. Stoddard, Milwaukee.
Discussion by Dr. Arnold Jackson, Madison.

11:25. "Differential Diagnosis of Hyperthyroidism and Neuroses."
Dr. A. L. Mayfield, Kenosha.

PERE MARQUETTE ROOM

Dr. A. F. Kastner, Presiding

8:00. "Interpretation of Roentgenograms of the Skull in Children." Lantern Slides.
Dr. Helen J. Zillmer, Milwaukee.

8:25. "Convulsions in Children." Lantern slides and moving pictures.
Dr. M. G. Peterman, Milwaukee.

8:50. "Measles Encephalitis."
Dr. Max Fox, Milwaukee.
Discussion: Dr. J. L. Garvey and Dr. M. G. Peterman, Milwaukee.

9:15. "Acute Anterior Poliomyelitis: A Pediatric Problem." Lantern Slides.
Dr. F. R. Janney, Milwaukee.

9:40. *Intermission.*

10:10. "Upper Respiratory Infections in Children." Lantern Slides.
Dr. G. H. Fellman, Milwaukee.
Discussion: Dr. Ralph Sproule, Milwaukee—Complications in the ear and accessory sinuses. Dr. Roy M. Greenthal, Milwaukee—Complications involving the heart and lungs.

10:45. "Congenital Syphilis."
Dr. R. P. Schowalter, Milwaukee.

11:10. "Clinical Study of Vitamin D Milk; Its Use during Pregnancy as a Preventive of Rickets." Lantern Slides.
Dr. N. E. McBeath, Milwaukee, and Dr. H. O. McMahon, Milwaukee.

11:35. "The Suitable Time for Surgery in Children."
Dr. Irwin Schulz, Milwaukee.

ENGLISH ROOM

Dr. H. B. Podlasky, Presiding

8:00. "The Relative Position of the Radiologist in the Medical Profession."
Drs. L. V. Littig, J. N. Sisk, and E. A. Pohle, Madison.

8:50. "Roentgen Therapy in Giant-Cell Tumor of Bone (with cases)."
Dr. Barton W. Johnson, Fond du Lac.

9:15. "Uterine Fibroids and Radium. (A resume of 370 cases)."
Dr. Austin O. Olmsted, Green Bay.

9:40. *Intermission.*

10:10. "Some Unusual Duodenal Pathology." Lantern Slides.
Dr. James A. Evans, La Crosse.

10:35. "A Roentgenological Evaluation of Nervous Indigestion."
Dr. F. H. Kuegle, Janesville.

11:00. "Roentgenology in the Diagnosis of Thoracic Lesions." Lantern Slides.
Dr. R. P. Potter, Marshfield.

11:25. "Pulmonary Tuberculosis in Childhood."
Dr. S. M. Welsh, La Crosse.

12:00–2:00 P. M. ROUND TABLE LUNCHEONS.
(Admission by ticket from Secretary only.)

1. Dr. O. R. Lillie, Milwaukee. *Parlor A, 4th Floor.*
"Appendicitis."
2. Dr. Stanley Seeger, Milwaukee. *Parlor B, 4th Floor.*
"Treatment of Carcinoma of the Colon and Rectum."
3. Dr. F. J. Gaenslen, Milwaukee. *Parlor C, 4th Floor.*
"Fractures of the Foot and Ankle."
4. Dr. W. E. Grove, Milwaukee. *Parlor D, 4th Floor.*
"Vasomotor or Hyperesthetic Rhinitis."
5. Dr. James C. Sargent, Milwaukee. *Parlor E, 4th Floor.*
"Intravenous Urography; Its Virtues and Limitations."
6. Dr. J. L. Yates, Milwaukee. *Parlor F, 4th Floor.*
"Surgery of Pulmonary Tuberculosis."
7. Dr. H. B. Podlasky, Milwaukee. *Parlor G, 4th Floor.*
"Gall-Bladder Symposium."
8. Dr. Jos. Lettenberger, Milwaukee. *Room B, 5th Floor.*
"Newer Remedies; Their Clinical Value in General Practice."
9. Dr. W. J. Egan, Milwaukee. *Room C, 5th Floor.*
"Gastro-Intestinal Diseases."
10. Dr. Karl Kassowitz, Milwaukee. *Parlor H, 4th Floor.*
"Chronic Infections of the Lung in Childhood."
11. Dr. Carl Henry Davis, Milwaukee. *Room D, 5th Floor.*
"Periodic Examination of Women Patients; With Special Attention to Prevention and Early Diagnosis of Uterine Cancer."
12. Dr. Oscar Lotz, Milwaukee. *Parlor I, 4th Floor.*
"Diseases of the Chest."

2:10 P. M. GENERAL SESSION. GRAND BALL ROOM.

2:10. "President's Address."
Dr. Reginald Jackson, Madison.

2:30. "Reducing Prescription Costs. Economies by Prescribing Standard Pharmaceuticals."
Mr. Herman L. Emmerich, Past President Wisconsin Pharmaceutical Association, Milwaukee.

2:55. Report of Elections.
Mr. J. G. Crownhart, Secretary.

3:05. "The Dawn of a New Specialty in Medicine: Allergy." Lantern Slides and Moving Pictures.
Dr. W. W. Duke, Kansas City, Missouri.

3:35. *Intermission.*

3:50. "Observations on Some Abdominal Conditions in Childhood."
Dr. Samuel Amberg, Rochester, Minn.

4:10. "Oration in Medicine. The Parathyroid Glands and their Relation to Calcium Metabolism."
Dr. David Barr, St. Louis.

7:00. GRAND BALL ROOM. ANNUAL DINNER. INFORMAL.
Presentation of The Council Award.
Speaker of the evening: Dr. Richard E. Scammon, Dean of Medical Sciences, University of Minnesota, Minneapolis. "The Foundation and Early History of St. Bartholomew's—the first Hospital in London."
Dancing—Cards.

FRIDAY, SEPTEMBER 16

PERE MARQUETTE ROOM

Dr. Arthur J. Patek, Presiding

8:00. "Spontaneous Pneumothorax." Viewbox Illustrations.
Dr. Herbert P. Benn, Stevens Point.

8:25. "Primary Carcinoma of the Lung."
Dr. William Jermain, Milwaukee.

8:50. "Bronchoscopic Examination as an Aid in Obscure Pulmonary Conditions." Lantern Slides.
Dr. John S. Gordon, Milwaukee.

9:15. "Asbestosis."
Dr. Ralph G. Mills, Fond du Lac.

9:40. *Intermission.*

GRAND BALLROOM

Dr. D. E. W. Wenstrand, Presiding

8:00. "Obstetrical Analgesia."
Dr. R. H. Ludden, Viroqua.

8:25. "Prevertebral Abscesses. Case report with lantern slides."
Dr. F. C. Christensen, Racine.

8:50. Acute Abdominal Surgery from the Standpoint of the General Practitioner."
Dr. L. O. Simenstad, Osceola.

9:15. "Diaphragmatic Hernia."
Dr. Robert Blumenthal, Milwaukee.

9:40. *Intermission.*

ENGLISH ROOM

Dr. E. A. Fletcher, Presiding

8:00. "Roentgen Ray Exploration of the Pelvic Viscera with the Aid of Brominized Oil."
Lantern slides.
Dr. Joseph J. Eisenberg, Milwaukee.

8:25. "Etiology and Pathology of Renal Infections. (So-called "Surgical Kidney.") Lantern Slides.
Dr. William Carson, Milwaukee.

8:50. "The Chronic Infected Prostate."
Dr. Cyril G. Richards, Kenosha.

9:15. "Trans-Urethral Resection of Prostatic Obstruction." Lantern Slides.
Dr. James C. Sargent, Milwaukee.

9:40. *Intermission.*

10:00 A. M. GENERAL SESSION. GRAND BALL ROOM.

10:00. "Report of Delegates to the American Medical Association."
Dr. W. E. Bannen, La Crosse.

10:25. "The Effect on the Lungs of Fungus Spores Found in Maple Bark." Lantern Slides.
Dr. J. W. Towey, Powers, Mich.

10:45. "Finding Tuberculosis in Apparently Healthy Youth."
Dr. A. A. Pleyte, Milwaukee.

11:05. "The Leukopenic Syndrome."
Dr. Fred Madison, Milwaukee.

11:25. "Leukopenia and Acute Leukemias with the Differential Diagnosis from Similar Blood Conditions."
Dr. Charles H. Watkins, Rochester, Minn.

1:40 P. M. GENERAL SESSION. GRAND BALL ROOM.

1:30. "The Female Sex Hormone." Lantern Slides.
Dr. Elmer L. Sevringhaus, Madison.

1:50. "The Clinical Significance of Recent Advances in Medical Science."
Dr. Wm. D. Stovall, Madison.

2:10. "Injuries to the Heart and Aorta." Lantern Slides.
Dr. L. M. Warfield, Milwaukee.

2:30. "The Treatment of Heart Disease."
Dr. Ellsworth S. Smith, St. Louis.

3:00 *Intermission.*

3:10. "Clinical Aspects of Bright's Disease."
Dr. Francis D. Murphy, Milwaukee.

3:30. "Etiology and Pathology of Nephritis." Lantern Slides.
Dr. E. T. Bell, Minneapolis.

4:00. "Constitutional Factors in Disease."
Dr. Julius Bauer, Vienna, Austria.

SCIENTIFIC EXHIBITS

1. Milwaukee Health Department.
   Exhibit of material from the Milwaukee Health Department and other welfare and health organizations which won for Milwaukee first place in the National Inter-Chamber Health Conservation Contest.
2. Wisconsin Anti-Tuberculosis Association.
3. Muirdale Sanatorium.
4. Mount Sinai Hospital.
5. Chemical Laboratory of the American Medical Association.
   Posters and specimens bearing on the subject of newer synthetics, comparative prices of proprietary and nonproprietary remedies, and drug control.
6. Dr. A. Levinson, Chicago, Ill.
   Cerebrospinal fluid in health and disease. Exhibit consisting of charts and slides showing chemical and physicochemical studies of the spinal fluid; comparative studies of blood and of lumbar and cistern fluid in children; and cerebrospinal fluid changes in various conditions. The exhibit is designed to show the most recent investigations on cerebrospinal fluid.
7. Dr. M. G. Peterman, Milwaukee.
   Two motion pictures entitled "Convulsions in Infancy and Childhood" and "The More Common Dystrophies in Childhood." Charts, graphs, and photographs of interesting cases.
8. Dr. E. J. Carey, Milwaukee.
   Exhibit of models and charts illustrating the mechanical forces involved in movements and deformities of the spine.
9. Dr. S. M. Markson, Milwaukee.
   Exhibit of photographs illustrating unusual dermatoses.
10. Dr. F. D. Murphy, Milwaukee.
    Exhibit of pathological specimens illustrating the various types of kidney disease.
11. Dr. M. N. Federspiel, Milwaukee.
    Exhibit illustrating the various diseases and deformities encountered by the oral surgeon.
12. Moving picture.
    The Harvey Film on the Circulation of the Blood.
13. Exhibit on Poliomyelitis. Bureau of Exhibits, American Medical Association.
14. Pregnancy Diagnosis. Dr. E. L. Severinghaus, University of Wisconsin.

TECHNICAL EXHIBITS

Seventeen booths have been reserved for the technical exhibit. The exhibits will occupy the hall opposite and adjacent to that in which the scientific sessions will be held. Among those who will exhibit at this meeting are:

Booth No.	*Exhibitor*
1	Medical Protective Company
2	Mead Johnson & Company
3	Mellin's Food Company
4	Victor Mueller Company
5	Scanlan–Morris Mfg. Company
6	E. H. Karrer Company
7	Roemer Drug Company
8	W. B. Saunders Company
9	Horlick's Malted Milk Corporation
10	H. G. Fischer & Co. Inc.

(Continued on page 660)

PRESS SERVICE OF STATE MEDICAL SOCIETY

No serum does so much for public health as printer's ink

HEAT PROSTRATION

Madison, Wis., July 28.—There will be few fatalities from heat prostration if the person affected could be immediately removed to some cool and comfortable place and given proper care. Under no conditions should one delay in calling the physician, for cases of sunstroke may result fatally, and expert care must be given at once.

This warning was issued by the Educational Committee of the State Medical Society in a bulletin issued today. It declares that many of the fatalities of one year ago might not have occurred had proper precaution been taken.

"Heat prostration or heat exhaustion is a collapse due to the effect of high temperature on the body. It is most apt to occur when one has undertaken heavy or unusual physical exertion," declares the bulletin today. "It is milder in form and less serious in its after-effects than sunstroke, which is usually caused by prolonged exposure to the rays of the sun.

"In cases of heat exhaustion (not sunstroke) the temperature of the patient rarely rises above 103 degrees and may be below normal; the face is pale, the skin is cool and covered with a clammy perspiration, and the patient is conscious; sunstroke on the other hand, is marked by a temperature running as high as 110 or 112; the face is flushed; the skin is hot and dry, and unconsciousness comes at once, the patient often dropping as if struck by a bullet.

"When a person collapses from the heat exhaustion, the first thing to do is to call a physician, but while waiting for him to respond there are a number of things that can be done to make the patient more comfortable and to give him a greater chance of recovery. In heat prostration the person affected should be removed to as cool a place as possible, placed flat on the back with the head low and a light covering thrown over the body. A mild stimulant may be given. In cases of sunstroke, however, an effort should be made to lower the temperature of the body by ice packs on the head, ice water sponging of the body, and if necessary, a cold bath until the body temperature is lowered to around 102 and consciousness returns. Under no conditions delay in calling a physician, for cases of sunstroke may result fatally, and expert care must be given at once.

"The after-effects of sunstroke are much more serious than those of heat prostration. Permanent inability to withstand high temperature often results, while loss of mental concentration or memory are frequently noticed.

"Prevention is better than cure. During periods of excessive heat, eat wisely, confine the diet largely to green vegetables, milk and other light foods, work but moderately, drink an abundance of water, get plenty of sleep, and avoid long exposure to the sun. Keep the body in the very best of condition.

* * *

FOOD FOR THE CHILDREN

Madison, Wis., Aug. 4.—Because children do not chew their food as well as older people, greater care should be taken in giving them edibles that have been well cooked. Much of the digestive disturbances which children suffer is due to improper cooking, in the opinion of the Educational Committee of the State Medical Society.

A bulletin issued by the Society today declares that too few children are given sufficient vegetables and fruit. The bulletin points out that these foods supply a certain amount of body fuel, but this is not their chief use; they are of special value as sources of vitamins and mineral matter.

"Well cooked, clean, wholesome food of the right kind and in proper quantities will go further than any other factor in insuring children greater health and development," declares the bulletin. "Old people do not need the suggestive service which is required for younger children. Meals for children should be served attractively to inculcate a sense of neatness and order.

"In some families children do not get enough meat and eggs; in others they get too much. A good general rule commonly followed is to give a child two years old or over an egg every other day, and about the same amount (two ounces) of meat, fish, or poultry on the days that come between. If, for any reason, these are omitted from the child's diet, special care must be taken to see that other suitable foods take their place—preferably an extra amount of milk.

"Broiling and roasting are the best methods of preparing tender meat. Tough meat should be stewed or prepared in a fireless cooker, or first chopped and then broiled.

"It is important to teach children to chew meat and other foods properly.

"Fried meats, particularly those which are pan fried or cooked in a small amount of fat, should not be given to young children. One reason for this is that they are likely to be overcooked and tough, at least on the outside, and so are likely not to be properly chewed and to be swallowed in large pieces. Another reason is that the fat used in frying and also that which fries out of the meat is likely to be scorched and changed in composition. When this is the case, it is almost certain to be harmful."

* * *

POISON IVY

Madison, Wis., Aug. 11.—That three-leaved plant in the woods that turns reddish in August with the fall sumach is one of the most poisonous of all plants in the woodland.

Poison ivy has three leaves.

Woodbine, which is non-poisonous, has five leaves.

Hundreds of cases of ivy poisoning, which occur each year, could be obviated if people would count the leaves on the creeping plants and leave the three-leaved plants alone.

"Woodbine and poison ivy are very easily distinguished, for woodbine has five leaves while ivy has but three,—the same number as there are letters in the word," declares the bulletin of the State Medical Society issued today. "Two of the leaves are short stalked while the third or terminal leaflet is long stalked.

"Poison ivy leaves are shiny or wax-like, except in the early spring, while woodbine leaves are dull. The berries of the woodbine quickly turn to a deep blue; the ivy bears smooth, greenish berries which change later to a yellowish white, or ivory color.

"The berries remain on the plant until late in the winter and are about a fourth of an inch in diameter.

"Poison ivy, as well as woodbine, tends to trail along the ground, or climb over brush or fences. Both often grow on trees. But don't forget that ivy, under favorable conditions, can grow as a shrub three to four feet high or even assume the proportions of a young tree.

(Continued on page 658)

THE JOURNAL BOOK SHELF

Clinical Interpretation of Laboratory Reports. By Albert S. Welch, A. B., M. D., clinical instructor in medicine in the University of Kansas School of Medicine in Kansas City, Kansas; director of the laboratory of the Alfred Benjamin Dispensary, and attending surgeon of St. Joseph's Hospital in Kansas City, Mo. Sixteen illustrations. Price $4.00. P. Blakiston's Son & Co., 1012 Walnut Street, Philadelphia.

Materia Medica, Pharmacology and Therapeutics. By Walter A. Bastedo, Ph. G., M. D., assistant clinical professor of medicine, Columbia University; consulting physician, St. Luke's Hospital, New York, St. Vincent's Hospital, Straten Island and the Staten Island Hospital; President, United States Pharmacoloeial Convention, 1930–40. Price $6.50 net. Third edition. W. B. Saunders Company, Philadelphia, 1932.

A Manual of Pharmacology. By Torald Sollmann, M. D., professor of pharmacology and materia medica in the School of Medicine of Western Reserve University, Cleveland, Ohio. Fourth edition, thoroughly revised. Octavo of 1237 pages. W. B. Saunders Company, Philadelphia. 1932. Price $7.50 net.

The Costs of Medicines. The manufacture and distribution of drugs and medicines in the United States and the Services of Pharmacy in Medical Care. By C. Rufus Rorem, Ph. D., C. P. A., and Robert P. Fischelis, B. S., Phar. D. Price $2.50. University of Chicago Press, Chicago, Illinois.

The Expectant Mother's Handbook. By Frederick C. Irving, A. B., M. D., professor of obstetrics, Harvard Medical School; visiting obstetrician, Boston Lying-in Hospital. With illustrations. Price $1.75. Houghton Mifflin Co., Boston.

Pain in the Pleura Pericardium and Peritoneum. By Joseph A. Capps, M. D., professor of clinical medicine, University of Chicago with the collaboration of George H. Coleman, M. D., assistant professor of medicine, Rush Medical College. The Macmillan Company, New York, Price $3.00.

New and Nonofficial Remedies, 1932, containing descriptions of the articles which stand accepted by the Council on Pharmacy and Chemistry of the American Medical Association on Jan. 1, 1932. Cloth. Price, postpaid, $1.50. Pp. 492. lvi. Chicago: American Medical Association.

Annual Reprint of the Reports of the Council on Pharmacy and Chemistry of the American Medical Association for 1931. Cloth. Price, $1.00. Pp. 100. Chicago: American Medical Association.

Physician's Manual of Birth Control by Antoinette F. Konikow, M. D. 1931, Buchholz Publishing Com., 1440 Broadway, New York.

Practical Treatment of Skin Diseases. With special reference to technique. By Edward Ahlswede, M. D., formerly assistant physician, University Skin Department, direction of Prof. Unna, Eppendorf Hospital, Hamburg; assistant physician, Clinic and Research Laboratory, direction of Prof. Unna, Hamburg; Assistant physician, Institute of Physical Therapy, direction of O. Ahlswede, M. D., Hamburg. 77 illustrations. Price $12.00. Paul B. Hoeber, Inc., New York.

BOOKS RECEIVED FOR REVIEW

Introduction to Dermatology. By Richard L. Sutton, M. D., professor of diseases of the skin, Universtiy of Kansas School of Medicine, and Richard L. Sutton, Jr., M. D., visiting dermatologist to the Kansas City General Hospital. With 183 illustrations. Price $5.00. C. V. Mosby Company, St. Louis, 1932.

Principles of Chemistry. By Joseph H. Roe, Ph.D., professor of biochemistry, George Washington University Medical School; lecturer in chemistry, Central School of Nursing, Washington, D. C.; captain, sanitary division, U. S. Medical Reserve. Third Edition. Price $2.50. C. V. Mosby Co., St. Louis, 1932.

Diabetes in Childhood and Adolescence. By Priscilla White, M. D., physician at the New England Deaconess Hospital, Boston. Price $3.75. Lea & Febiger, Philadelphia, 1932.

Nursing in Nervous Diseases. By James W. McConnell, M. D., neurologist to the Philadelphia General Hospital. Illustrated with 24 engravings. Price $1.50. F. A. Davis Company, Philadelphia, 1932.

Your Teeth and Their Care. By Carl W. Adams, D.D.S., San Bernardino, Calif. Illustrated. Price $1.25. C. V. Mosby Co., St. Louis, 1932.

American Illustrated Medical Dictionary. (Sixteenth Edition) A complete Dictionary of the terms used in Medicine, Surgery, Dentistry, Pharmacy, Chemistry, Nursing, Veterinary Science, Biology, Medical Biography, etc. By W. A. Newman Dorland, M. D., Member of the Committee on Nomenclature and Classification of Diseases of the American Medical Association. Sixteenth Edition, Revised and Enlarged. Octavo of 1493 pages, 941 illustrations, 279 portraits. Philadelphia and London: W. B. Saunders Company, 1932. Flexible and Stiff Binding, Plain $7.00 net; Thumb Index $7.50 net.

BOOK REVIEWS

Any scientific publication reviewed in this column may be obtained for inspection. Orders for such inspection should be directed to the Medical Library Service, 424 N. Charter Street, Madison, Wis.

Minor Surgery of the Urinary Tract. By Herman C. Bumpus, Jr., Ph. B., M. D., in urology, F. A. C. S., section on urology, the Mayo Foundation. Octavo of 124 pages with 57 illustrations. Price $3.00 net. W. B. Saunders Company, Philadelphia. 1932.

This small monograph of about 115 pages is divided into ten chapters and every chapter is filled with valuable information. The more important subjects discussed are—caruncles of the urethra, stricture of the urethra, hypertrophy of the prostate

LOOK

behind the

TRADE

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We appreciate the fact that, in solving certain investment problems, it may occasionally be desirable for the investor to substitute one security for another — in good times as well as bad—in order to improve his investment account.

We feel, however, that it is always wise to look behind any suggested trade with these questions in mind:

Does the recommendation represent the policies and experienced executive judgment of a well-established investment organization? And: Is the recommendation based on careful analysis of all factors pertinent to the client's investment problem?

It is our belief that the investor who maintains this attitude toward trading can greatly clarify the problems of building a sound and well-balanced investment account.

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gland, carcinoma of the prostate, vesical calculi, vesical neoplasms, cystitis, ureteral calculi, and postoperative care.

The discussion based on the very large experience of Dr. Bumpus and his associates at the Mayo Clinic is clear and concise.

The chapters on hypertrophy of the prostate gland and postoperative care are of unusual interest, as the former is given over largely to a discussion of transurethral resection of the prostate by the method developed by the author. In the latter is a discussion of the ketogenic diet in the treatment of urinary tract infections.

Though of general interest the volume will be of especial value to those whose activities are largely in the field of genitourinary diseases. I. R. S.

"Human Sterilization," J. H. Landman, Ph.D., J. D., The Macmillan Co., New York (Publishers)—1932.

There is a fund of information compiled in this little book. Much more than a discussion of sterilization is contained in the text because the author has approached the problem in such a very thorough and scientific manner.

Chapters one and two dealing with the eugenics movement and the statistics on the mentally incompetent people in the United States might well be read by any intelligent layman but, more especially, medical students and physicians. As the author states, the book is not propaganda but amounts to a very clear and concise statement of known facts and scientific data. Chapter two presents recent statistics on the prevalence of psychoses, mental enfeeblement, etc. A perusal of this chapter will convince anyone of the serious problem that confronts society; a problem that has forever been before us but because no striking changes have occurred is met with almost indifference on the part of the laity and the medical profession as well.

Chapter three gives the history of sterilization efforts in the United States and should be interesting to the physician, lawyer and layman as well.

Chapter four deals with the legal status of sterilization laws and should be interesting reading for the medical student and physician. It serves as an example of the need of the practicing physician being at least reasonably familiar with the legal aspects of medicine in relation to the public.

Chapter seven, dealing with the nature of our socially inadequate people, is a very brief presentation of the various psychoses in which the author follows the classification used by the American Psychiatric Society and, while it is not by any means a text on the psychoses, yet would be good reading for the medical student before he takes up psychiatry.

Chapter eight deals with the heredity of psychotic traits and conforms to the generally accepted views held at the present time by the majority of scientific investigators.

In chapter nine the inheritance of mental deficiency is discussed and the author here, as elsewhere in the book, carries a large number of references which would be helpful to the student who is interested.

Throughout the book the author discusses nature and nurture or biological heritage as opposed to the influences of environment, a question which constantly comes up in the realm of medicine and can again profitably be read by the medical student.

Chapter eleven deals with the surgical aspects of human sterilization in both the male and female and chapter twelve deals with the effects of vasectomy and salpingectomy upon the sexual function and the individual's subsequent adjustability to social situations.

Chapter fourteen deals with the purpose of sterilization, that is, the eugenic motive, the therapeutic motive, punitive motive and the abusive and malicious motives which have no part in the general theme.

The remaining chapters deal with the administration of sterilization laws. As already stated, many references that appear throughout the text are gathered and the most important shown under the bibliography that is very complete and up to date.

As one interested in the teaching of medicine, I indorse this book and would recommend that medical students be required to read it before entering their third and fourth years of the medical curriculum mainly because it contains so much data from authoritative sources and presented in a readable fashion having value far beyond the theme presented in the title. W. F. L.

Diseases of the Coronary Arteries. By Don C. Sutton, M. S., M. D., associate professor of medicine, Northwestern University; attending physician, Cook County Hospital; Chief of Cardiac Follow-Up Clinic, Cook County Hospital, Chicago, and Harold Lueth, Ph. D., M. D., formerly instructor in physiology, Northwestern University, Chicago.

In this compact volume, the authors have, in a space of 160 pages, included all the essential information concerning coronary artery disease of value to the practicing physician. The book is designed primarily for the general practitioner rather than the man who specializes in cardiovascular disease. Contrary to the usual textbook arrangement, symptomatology and physical findings are described before the underlying principles of anatomy physiology, pathology and pharmacology are discussed.

The chapter on physiology and pharmacology contains a very complete list of the most important researches and a brief statement of the results of each as they bear on the subject in hand. The section on treatment is particularly well written and presents the very latest forms of therapy together with just enough case histories to inform the reader as to what benefit may be expected from the types of therapy suggested.

There is an excellent bibliography covering practically all of the important papers dealing with the experimental work and clinical investigations which have been carried out along this line in recent

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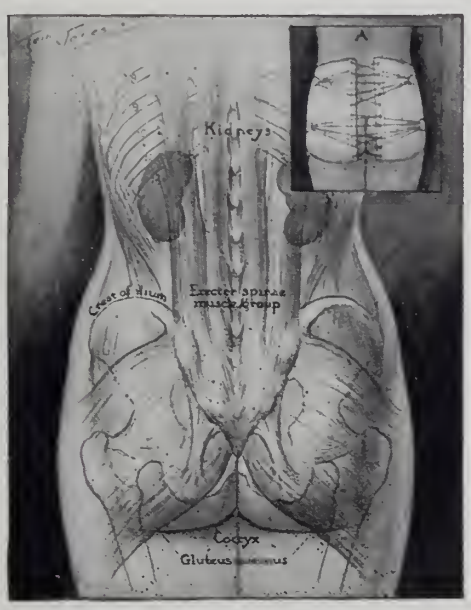
ANATOMICAL STUDIES



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years. The student who wishes to delve more deeply into any particular phase of the subject will find this most helpful.

The book is well illustrated, particularly the section dealing with pathology. Numerous electrocardiograms are shown, but the authors have failed to to discuss the characteristic changes in the electrocardiogram by which the diagnosis of coronary thrombosis can frequently be confirmed and the successive developments by which the progress of the healing process can often be determined.

This volume should be of real value to the general medical man, not only in aiding him to recognize cases of coronary disease, but more especially in outlining definite methods of treatment which until recently have been sadly lacking in this only too prevalent and ever increasing condition. C. M. K.

Electrosurgery. By Howard A. Kelly, M. D., Baltimore, Md., and Grant E. Ward, M. D., Baltimore. 305 pages with 382 illustrations. Price $13.00 net. W. B. Saunders Company, Philadelphia, 1932.

A very thorough book which begins with the fundamentals explaining very clearly the physics of electrosurgery. It shows by experimental work the effect of electrosurgery upon tissue, both in the amount of destruction and in the repair. Each field of surgery is covered in special chapters. The book is very well written and has excellent illustrations. This work covers the subject of electrosurgery thoroughly and completely. It is a very desirable book for one interested in this subject. E. R. S.

1931 Collected Papers of the Mayo Clinic. Volume XXIII. Edited by Mrs. Maud H. Mellish-Wilson and Richard M. Hewitt, B. A. M. A., M. D. Octavo volume of 1231 pages with 265 illustrations. Price $13.00 net. W. B. Saunders Company, Philadelphia, 1932.

The yearly volumes of the collected papers of the Mayo Clinic are of great service to the medical profession. This volume, like its predecessors, gives in one volume the research and clinical work done by the members of the clinic in the year 1931. For any medical man it is a convenient book to get into touch with the clinical and research work done at the Mayo Clinic. E. R. S.

PRESS SERVICE

(Continued from page 653)

"Poisoning usually occurs as a result of actual contact with some part of the plant. It is possible, however, that a person may be poisoned by the leaf hairs or pollen of the plant if only a short distance from it.

"The susceptibility of different persons varies but it has been established that there is apparently no such thing as absolute insusceptibility.

"If you have come in contact with poison ivy one of the surest and best ways to prevent the eruption is the use of soap and hot water for the poison requires some time to penetrate the skin. A stiff brush should not be used as this might tend to drive the poisonous material further into the skin. Use a heavy lather and continue the washing for about 4 or 5 minutes with several pledgets of cloth or gauze—discarding each in turn. Change the water frequently or use running water and don't let the lather or water touch unexposed areas of skin. Repeat the process in 4 to 5 hours. Alcohol, diluted about one-half, is also of value in washing exposed skin as it exerts a solvent action on the poison. The irritation from the eruption may be allayed by immersing the inflamed surface in hot water for several minutes, gradually increasing the temperature until the water is as hot as can be borne. If the eruption is on the face apply the hot water by means of towels. Cooking soda or borax on bandages (a teaspoon to a cup of water) is of value, but the bandages should not be tight and should be frequently changed. Ointments should not be used in the early stages. A bad case of ivy poisoning always requires the attention of a physician. In any case if there is a fever, severe pain or headache, it is much safer to call a physician at once."

* * *

THE DECLINE OF TUBERCULOSIS

Madison, Wis., Aug. 18.—"To watch your favorite athletic team drop from first place to fifth is rather disheartening. To see one of the so-called 'Captains of Death' take exactly that tumble is a different matter. This is, however, just what tuberculosis has done. Rated in 1910 as the leading cause of death in the United States, it now holds fifth place."

Reasons for the annual decline of the death rate from tuberculosis were outlined by the Health Committee of the State Medical Society of Wisconsin in a bulletin issued today.

Here is what has happened to the tuberculosis death rate in Wisconsin.

1910.....	103.0 deaths per 100,000 population.
1915.....	94.0 deaths per 100,000 population.
1920.....	85.6 deaths per 100,000 population.
1926.....	66.4 deaths per 100,000 population.
1928.....	59.0 deaths per 100,000 population.
1930.....	51.5 deaths per 100,000 population.
1931.....	48.2 deaths per 100,000 population.

"There are two important factors to explain this remarkable decrease," declares the bulletin of the Medical Society. "First and foremost, the campaign of education that has been carried on in our own state as well as the whole country. People no longer throw up their hands in despair when their physician tells them they have tuberculosis. We have supplanted the idea that consumption is incurable, by the knowledge that tuberculosis can be cured if it is diagnosed early and proper treatment is begun early. We have found out that the sanatorium is a place to treat and cure tuberculosis; that the sanatorium is not an asylum in which the unfortunate victims of this disease may spend their few remaining days. This demand for treatment has resulted in the increase of sanatorium beds in Wisconsin from one hundred and forty beds in 1910 to eighteen hundred beds in 1931.

"The second factor controlling this decreased death rate from tuberculosis is the increased average length of life. For tuberculosis is a disease belonging to young people—the older one grows, the less liable is it to develop. With the bettered living conditions, people live on through the tuberculous age to the period in which the diseases of old age, heart disease, kidney disease, cancer, and pneumonia claim their toll.

"There is one thing everyone can do to prevent being numbered among the tuberculous. See that he or she has, once each year, a thorough, complete and competent physical examination. Early discovery means early recovery."

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A half century ago more than fifty percent of the diphtheria cases terminated in death. With Diphtheria Antitoxin, Lilly, for treatment and for passive immunization, and Diphtheria Toxoid, Lilly, and Toxin-Antitoxin Mixture, Lilly, for active immunization, every physician has at hand efficient weapons against the disease.

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INCIDENCE OF ILLNESS

Madison, Wis., Aug. 25.—Ten per cent of the people of any community are always ill. Some have contracted a communicable disease; others have neglected their health in youth.

"That ten per cent rate could be reduced one-half in ten years if people would spend five minutes each day thinking of ways to keep well and then observing them," declares the State Medical Society's bulletin out today.

"President Eliot of Harvard said fifteen minutes reading each day would produce a well educated man in a few years," continues the medical society's warning. "Five minutes thoughtful consideration of one's health each day will give most people health in later life.

"One hears execration of alcohol and of social disease as a deadly danger, but heart disease alone, nearly all of which is preventable, takes twenty lives annually to every one taken by alcohol. The mother always carries the burdens of illness and sorrow and it is to her eyes usually that the early evidences of oncoming disease, become apparent. When you, as actual or potential mothers, realize that at least half of the crippling disabilities and infirmities may be avoided by preventive measures, the medical profession will have your earnest and hearty support in this movement of prevention.

"It is a fact that ten per cent of our population are always ill. In a city of 20,000 people then, there are approximately 2,000 people ill at all times. Of this two thousand there will be about 40 cases of tuberculosis and the same number of cancer. There will be 250 ill with circulatory diseases and 150 with chronic kidney diseases. And the life of these 480 persons will be shortened by from 20 to 40 years to say nothing of impaired earning capacity, the suffering they must undergo and the tremendous discomfort and unhappiness imposed upon themselves and their families. And the larger part of these conditions might have been prevented.

"If we eliminate from discussion those diseases which you readily recognize as fatal, let us see what apparently simple conditions may do to lessen the span of human life. An actuarial investigation of two million persons by the New York Life Insurance Company shows that of those with a rise of blood pressure to but 141, there is an excess mortality of 9 per cent, while the excess mortality rate goes to 63 per cent in those with a pressure of 152 and 236 per cent excess mortality with a pressure of 171. And yet, no day goes by that we do not find a blood pressure of 170 or above on some person who did not even suspect it. At the age of 45, 40 pounds overweight shows an excess mortality of 50 per cent. In other words, 3 die when but 2 should. In a health examination based upon supposedly healthy people, in 4100 consecutive persons, taken just as they appeared, only 74 had normal teeth and 58 per cent, or 2700, had actual root abscess. Six hundred and fifty-eight had well marked kidney damage and 492 had combined heart and kidney damage. And of these less than 10 per cent had any idea of anything being wrong with them.

"Such tragic losses may be reduced by prevention and by early recognition of incipient disease."

ANNUAL MEETING

(Continued from page 652)

11 ----------Kremers–Urban Company
12 ----------Sharp and Smith
13 ----------Merck & Company
14 ----------Victor Hurley Company
15 ----------DeVilbiss Company
16 ----------General Foods Corporation
17 ----------General Electric X-Ray Corporation

GOLF TOURNAMENT

Every member who owns a set of clubs has been urged to come out and enjoy the good time attendant upon the Annual Golf Tournament to be held at the Tripoli Country Club on Tuesday, September 13th.

"We need not urge any to come who have ever enjoyed any of our previous tournaments, but we do especially urge the others to join with us for a day of good fellowship and good sport," declares Dr. F. A. Thompson, Milwaukee, Chairman of the tournament. "The course will be open at nine Tuesday morning for practice play and we will have our luncheon at twelve sharp. At one we tee off for the prizes that are headed by the President's and Secretary's Cups and at six we will have such a supper as only we do have at our annual tournament.

"Don't stay away simply because you haven't played much lately. Join us and enjoy the day out of doors and with the best companions ever."

Reservation blanks for the tournament were mailed each member the first of September. These should be returned to Mr. Theodore Wiprud, Mariner Tower, Milwaukee, at once. The entire cost of the tournament including the green fees, luncheon and supper will be $5.00.

HOUSE OF DELEGATES

That every member of the Society is welcome to attend meetings of the House of Delegates, was the message of President Fiedler this month. The House will hold its first session in the Grand Ballroom of the Schroeder Hotel beginning at seven sharp, Tuesday evening, Sept. 13th. The second session will be held in the same room at seven-thirty Wednesday evening and the last session at seven-thirty Thursday morning in the Loraine Room on the lobby floor of the Schroeder.

The House will act upon two amendments to the Constitution and By-laws at this session. The first provides that Councilors shall be non-voting members of the House.

PHYSICIANS' EXCHANGE

Advertisements for this column must be received by the 25th of the month preceding month of issue. A charge is made of $2.00 for the first appearance of copy occupying 1 inch or less of space and $1.00 for each succeeding insertion of the same copy. Kindly accompany copy with remittance to cover number of insertions desired. Advertisements from members of the State Medical Society will be accepted without charge. Such copy will be taken out after its second publication unless otherwise requested. Where numbers follow advertisements replies should be addressed care Wisconsin Medical Journal.

FOR SALE—Mobile Victor x-ray unit (in Milwaukee) either AC or DC currents, with 30 MA tube, including all dark room equipment and accessories. Practically new. Will sell at less than half the present market price. Address No. 881 in care of the Journal. JAS

FOR RENT—Office space for general practice above a corner drug store, in a residence neighborhood in Milwaukee. Dentist and oculist on same floor. Rent very cheap. Call Marquette 0217.

FOR SALE—$5000 practice in town of 1,000. Large territory southwestern Wisconsin. All gravel roads. Competition right. No real estate or personal property for sale. Terms reasonable and a bargain for cash. For further details address number 885 in care of the Journal. SO

FOR SALE:—10" direct current x-ray machine; dental chair, and Morse wave generator. Dr. Philip Eisenberg, 808 N. Third St., Milwaukee. Phone Marquette 0952.

WANTED: Used diathermy, Morse wave generator, infra red and quartz lamps, electric centrifuge, colorimeter and skeleton or parts. C. J. Yeager, 4 S. Genesee St., Waukegan, Illinois. ASO

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The second, proposed by the Committee on Medical Defense, would extend the time for delinquent members under the defense system from February first to March 31st of each year. Under the amendment medical defense must be paid by March 31st if coverage is desired for the first three months of the year.

When the House convenes on Tuesday evening Speaker Stanley J. Seeger of Milwaukee will announce his appointments to the four reference committees of the House: Credentials; Reports of Officers; Reports of Standing Committee and the fourth on Resolutions. Reports of officers and committees will be an early order of business at the Tuesday evening session. Immediately following these reports the House will hear the reports of two special committees. The first of these will come from Dr. Gilbert E. Seaman, Milwaukee, Chairman of the Special Committee on The Distribution of Medical Services in Wisconsin. The second report will be presented by Dr. Reginald Jackson, Chairman of the Special Committee to Investigate Admissions to the State of Wisconsin General Hospital. It is probable that while the reports will not receive definite action under the House rules until the Wednesday evening session, the floor will be opened for a full discussion immediately following the presentation of each report. Following the reports the House will select its Committee on Nominations composed of one delegate from each Councilor district. It will then proceed to the election of Councilors to succeed the following whose terms expire at this meeting: Drs. Spencer D. Beebe, Sparta; T. J. Redelings, Marinette; Joseph F. Smith, Wausau and H. M. Stang of Eau Claire.

Recommendations for the future conduct of the Society's efforts will be made by both Dr. Fiedler, the retiring President, and Dr. Reginald Jackson, President-elect. At this time Dr. Jackson will announce his committee appointments for confirmation by the House.

At the Wednesday evening session the House will hear the recommendations of its several reference committees and after further discussion proceed at once to act upon each. The Thursday morning session will be devoted to hearing the report of the Committee on Nominations and selecting officers for the coming year.

ALUMNI LUNCHEONS

The alumni luncheons for the alumni of Minnesota, Northwestern, Rush, Marquette, Illinois (Chicago P & S), Wisconsin and Michigan will be held at noon on Wednesday, the first day of the scientific sessions. The luncheons will each be held in private rooms as announced in the program printed in this issue.

ANNUAL DINNER

The Annual Dinner, informal, will be at seven Thursday evening, the second day of the scientific meetings. Immediately following the dinner President Fiedler will present Dr. Arthur W. Rogers, Chairman of the Council, who will make presentation for the third occasion of the Council Award. Dr. Richard E. Scammon, Dean of the Medical Sciences at the University of Minnesota, will be the single speaker of the evening presenting the subject of "The Foundation and Early History of St. Bartholomew's—the first Hospital in London." Dr. Scammon is an outstanding speaker. Following Dr. Scammon's address the Committee on Entertainment presents the finest dance orchestra in Milwaukee and the remainder of the evening will be given over to dancing and cards.

AUTOPSIES

(Continued from page 635)

that the attitude of the widower in conferring upon the body of his departed wife—the parent to that of his child—is personal. The body is not the person, but, perhaps unconsciously, is so viewed and treated for the purpose of these last rites of affection. Our statutes give general recognition to this idea by directing bodies of strangers or convicts to be delivered to their "relatives or friends." Secs. 1437, 4926, Stats. 1898. From this point of view, we think, are justified certain conclusions as to which, among the survivors, bear this duty and enjoy the right, which seem to be supported by the general current of authority. First among these is that the right is not vested in executors and administrators, as seemed to be suggested in some English cases quoted somewhat inconsiderately in this country. The right, such as we have suggested it, is not affected by the fact that the funeral expenses may properly be a charge upon the decendent's estate, and thus ultimately be payable by the executor or administrator. *Samuel v.*

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Estate of Thomas, 51 Wis. 549, 8 N. W. 361. That, however, is the only relationship which such an official has to the subject. An entirely sufficient practical obstacle to the vesting of either duty or right in such officers in most of the United States, including Wisconsin, is that they have no existence at the time when, according to custom, if not necessity, the duty must be performed. Even an executor does not become such until qualified by a court to act. *In re Somervaill's Will*, 104 Wis. 72, 80 N. W. 65. It seems, too, upon reason, and authority as well, that, in all normal and ordinary situations, mere intimacy of friendship should be eliminated, or at least subordinated to relations of kinship, as too intangible and indefinite for the law to lay hold of as a basis for either a legal duty or a legal right, although there are some cases where actual domestic relations had been created and held sufficient basis for the right and duty, as where a child was being reared in the family of those not related by blood or adoption. We have no doubt that, save for very exceptional conditions, the right of burial of a dead body rests primarily with those connected with the deceased, in life, by some ties of legal relationship, and we agree with the great weight of authority that foremost and closest in such relationship stands the surviving spouse. If, as we have indicated, this is but an extension beyond death of preexisting service and duties, what of those are in so close analogy as the service involved in the consortium between husband and wife—personal attendance, care, and service, shielding from insult, supply of necessities, and the like? Certainly none. Before them, all analogies drawn from property rights of inheritance in kinsmen by blood fail as reasons of legal precedence in the performance of these final duties to our departed. We cannot doubt that the word "relatives," in the above-cited statute, includes the surviving spouse, although in other statutes it may not. *Cleaver v. Cleaver*, 39 Wis. 96.

"In absence of any surviving spouse, situations become subject to such complications that it probably is not wise, if proper, to attempt to declare general rules beyond the case actually presented. Suffice it to say that the duty and right of the parent toward the body of a minor child dying a member of his household, or of the adult child toward a widowed parent, either a member of the child's family circle, or not a member of any other, seems too clear to warrant discussion."

It is very evident that there are many times when a physician must determine, at his peril, whether the persons purporting to give consent to an autopsy are the ones who may do so. In such instances, the physician should make it a practice to secure consent of all persons who might be interested, so far as possible.

The practice should also be followed of securing consent in writing.

The Koerber case also raised another interesting point,—namely, how far the physician may go in conducting the autopsy. In that case, consent was for examination of the stomach, but did not authorize its removal. It was removed, the corpse was buried without that organ, and the court recognized the right to damages. In an Iowa case, Winkler v. Hawkes, 126 Iowa 474, 102 N. W. 418, this subject is discussed briefly but fully, in the following language:

"Consent being given, we think it must be held to imply a permission to the surgeons to conduct such examination in the approved and usual manner practised by their profession; and, if the removal of some of the organs for microscopic examination was necessary or proper to effect the purpose of the post-mortem, then the defendants would not be guilty of an actionable wrong in so doing, *unless such permission was expressly withheld at the time the consent to open the body was given.*" (Italics ours.)

We now come to the question of when an autopsy may properly be performed without consent of those who have the right of custody and burial of the body.

There can be very little doubt as to the right of a coroner to conduct a post-mortem in his official capacity; and, of course, a physician employed by him to perform the duty is under his mantle of protection. In the Koerber case, at page 463, the court said:

"We recognize, of course, that public welfare may and does require governmental control in many respects for protection of life and health of the people, and for discovery of crime connected with the death of a person, and to such interests the private right is subservient so far as necessary. Upon this ground rest cases of autopsies upon dead bodies under public authority, and to satisfy police regulations for ascertainment of cause of death."

Of course, a coroner's autopsy must be in connection with an inquest. It may safely be said that in Wisconsin today inquests are authorized only when there is indication that the death was caused in some criminal manner. But the coroner has a wide discretion in determining when that is indicated. He cannot act arbitrarily, and the statute says there must "be good reason to believe," but when he acts in a good-faith belief murder or manslaughter is involved, founded upon any reasonable indication at all, he is within his jurisdiction. So far has this principle been carried, in furtherance of unham-

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pered and unafraid official inquiry into possible homicide, that the absence of any positive circumstances negativing homicide, as where a body is found in the street or field, may often be sufficient basis for a coroner's inquest, although it may be his duty to make preliminary inquiry to ascertain other easily discoverable circumstances before proceeding with a formal inquest. In deciding that an autopsy should be had, the coroner must, of course, not abuse his official discretion by acting arbitrarily and altogether unreasonably. He has no authority to proceed with an autopsy to determine cause of death or for any other purpose, where the circumstances are not such as hereinbefore set forth as the basis of his jurisdiction. For a more complete discussion of the coroner's duties and powers, see The Wisconsin Medical Journal for December, 1930, page 722.

The language of the court last quoted is broad enough to include an autopsy so that the cause of death may be shown in a death certificate. The court has not specifically passed upon this phase, however, and an autopsy for this purpose should always be made in good faith, with no more mutilation than necessary, and with reasonable regard for the feelings of relatives. Obviously, if consent can be secured, that course is desirable. Under the statute, the physician last in attendance before death is required to make a death certificate. If he requires an autopsy to do so, we believe, as indicated, that he may make it. If there was no physician in attendance, any physician may make the certificate, but, since he is not compelled to do so, there is grave doubt whether he ought to perform an autopsy without consent. The statute permits the local registrar of vital statistics to appoint a physician to make the death certificate, and a physician so acting may properly, we believe, perform an autopsy if it be necessary. This subject is discussed in a note in 52 A. L. R. at page 1450, where cases from Colorado, Kentucky, and Georgia are reviewed, sustaining the views we have expressed.

As a general rule, the fact of the deceased having been a public charge (as, an inmate of a county hospital, poorhouse, etc.) does not change the situation. The relatives of such a person have not lost their right to have custody and burial of the body.

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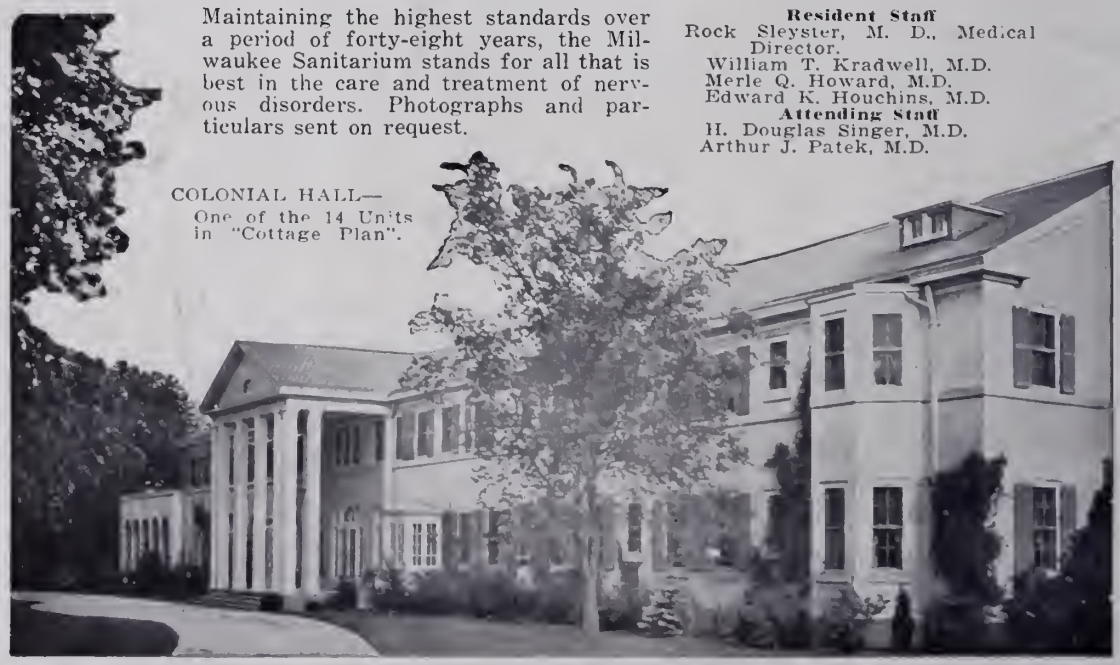

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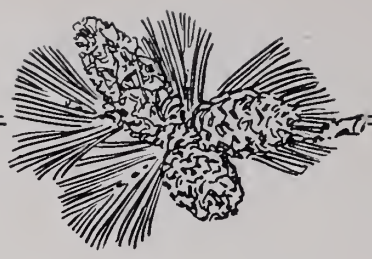

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Quo Vadis—O Physician of Wisconsin?*

By REGINALD H. JACKSON, M. D.
President, State Medical Society of Wisconsin, 1933
Madison

When I accepted, a year ago, the high honor and great responsibility of serving as President of the State Medical Society of Wisconsin, I stated that the future, the immediate future of medicine in this state was filled with vital economic problems, on the proper solution of which rested the welfare of our beloved profession. I promised to give my strength and ability to the utmost in helping to solve these problems in the interest of the general practitioner of medicine.

Why should we be so concerned with the welfare of the general practitioner?

1. Because he always has been, is now, and always will be the indispensable unit, the bulwark, the front-line contact man, the sine qua non of our profession.

2. Because society must recognize the fact that his preservation is fundamental to life, especially in rural and village districts. No conceivable change short of compulsory communistic state medicine can alter the importance of the vital function he fulfills. Normal village life, across the stage of which stalk all the vicissitudes of existence, including birth, disease, and death, is impossible without the hopefulness engendered by the presence of the general practitioner.

3. Forces over which he has no control are exerting such ever increasing pressure as to discourage and dishearten him in his efforts to carry on.

4. After a lifetime of faithful service the average net estate of the majority of practitioners is less than $15,000.

5. His annual net income is less than $3,500, while his average yearly service contribution to society, for which he receives no remuneration, is $2,200, and during his professional life it amounts to $66,000.

6. If he is obliged to abdicate his position through force of misdirected social economic pressure there will surely come the servile instruments of state medicine.

7. If that comes to pass, the very structure of our profession will be so weakened that the inner citadel, with its altar of altruism on which burns the flame of personal service rendered in an atmosphere of privacy, will slowly but certainly be destroyed.

8. If it is the duty of organized medicine to cherish and foster the ideal that the primary consideration of any system of medicine is the benefit it confers on the patient, it is no less its obligation to protect not only the public but itself, against the evils incident to any politicomedical system.

Just what are some of the problems which confront the general practitioner, especially one engaged in small town or village practice?

To visualize the background which is so essential in the composition of a picture, I shall take the liberty of disgressing for a moment from my theme.

The study of the growth of modern civilizations reveals certain facts common to all, due to the limited number of interactions possible when men are congregated in vast numbers constituting a social body or nation. Certain reactions are so uniform in occurrence that they may with reasonable certainty be forecast, although the exact time of their appearance may be hastened or delayed, according to the type of environment in which a given civilization is centered.

The particular reaction to which I would

* Address of the incoming President, presented before 91st Anniversary Meeting, State Medical Society of Wisconsin, Milwaukee, Sept. 15, 1932.

direct your attention is one which in the inevitableness of its appearance would seem to be the results of the working of a definite biosocial economic law. It relates to the so-called stratification of society whereby out of the toiling mass of humanity emerge certain layers composed of those who through inheritance, innate ability, perseverance, industry, or those who lack these qualities and are further unfortunate, find themselves placed at a given level.

In a long established civilization, the lowest or indigent layer is recognized as inevitable and of estimable thickness, necessitating proper consideration and allowance in governmental studies and budgets.

During pioneer settlement of states with great natural resources the social problem of the indigent and near indigent has been a negligible one as compared with the age-old problem in Europe.

One hundred years ago the area which constitutes the state of Wisconsin was considered a Siberian wilderness, unfit for the habitation of man. Out of this a veritable empire has been carved, and in that process many individuals wrought the miracle of transmuting themselves from the indigent to the upper layers of society, through their own exertions and industry plus the fortuitous circumstances of cheap land and opportunity.

FUTURE TRENDS

What of the future?

It becomes increasingly apparent that the same biosocial economic law will prevail here as it has elsewhere when conditions favor its action.

What bearing does this have upon the general practitioner in Wisconsin?

It is already exerting a very appreciable effect upon this generation who are in reality the very sons and disciples of the pioneers of our profession in this state.

My grandfather's certificate of membership in this society was issued in 1856, at the fourteenth annual meeting; my father became a member in 1883; and now the ninety-first anniversary meeting is in session. Great, indeed, are the changes which have come to pass not only in the art and science of medicine but also in the social economic problems of society, in these intervening years.

Such changes in this relatively short span of years should awaken us to a vivid realization of our duty, while viewing with retrospective pride an honored past, to note the changing signposts along the pathway of the general practitioner of medicine in order not only to ascertain his position of today but to counsel, guide, and if necessary, redirect him and his successors into a better thoroughfare of a long tomorrow.

While he must altruistically and charitably continue to bear his just share of the burden which the constantly increasing complexity of our social life places upon him, we should make it very clear to society that unless it constructively cooperates with the medical profession in making the present burden of the general practitioner lighter it must inevitably do without his services in many places.

Society, once made conscious of the actual situation, will surely take measures to remedy it and will not knowingly continue to take an unfair advantage of the general practitioner by permitting its agents to utilize that most impelling human proclivity—the desire to get something for nothing when it is feasible and within the law.

The statute enacted in 1849 and still in force, states that it is the duty of society to care for its indigent sick.

How has this been actually done? Ostensibly through state, county, or township aid; and undoubtedly the average citizen thinks that it has practically all been done in this way. He could not possibly conceive of any group of citizen taxpayers so altruistic or muddle-headed as to carry the major proportion of this burden voluntarily.

Is it not time to tell society what that portion of this burden which our profession has carried amounts to?

During the past thirty years, the average professional life of a physician, the medical profession in this state has contributed in unremunerated professional service the carefully estimated sum of $180,000,000. What has our profession received in lieu of monetary reward?

Public approbation? Gracious acknowledgment? Encouragement? Not such that we blush with embarrassment when it is mentioned!

But is not the physician always glad to render service to the sick without regard to race, creed, color, or economic status? Does he not feel it an ethical obligation to do so? What changes have taken place that he should now become critical, when for so long he has been complacent in carrying this burden for society?

O tempora! O mores! Let us turn back the page and view the general practitioner of the past as contrasted with his fellow of today.

Formerly self-sufficient with limited educational equipment for which he had expended a mere pittance in time and financial outlay, as compared with his fellow of today of whom society demands, before he can even obtain a license, eight or ten years' preparation at a cost of many thousands of dollars. Formerly the graduate of two courses of lectures of six months each, equipped with a bag of medicines, a stethoscope, and a pair of obstetrical forceps entered upon practice. An occasional call upon his time and generosity in attending the indigent sick was of small moment and well rewarded not only by the self satisfaction which attends a good deed but also by the knowledge that it was appreciated by his fellow citizens. Today, 40 per cent of his professional services are charitable. No other profession has made greater advances in its educational requirements than the medical profession.

The conception and administration of the laws for the treatment of the indigent sick in this state, so far as they pertain to any just, fair remuneration for the majority of physicians and hospitals who render the service, are so inadequate that a determined effort must be made to improve the situation through justifiable appeal to legislative action. Not but that certain counties and townships live up to the commandment, "do unto others as you would they should do unto you", in dealing with the general practitioner, but because in so many places the governing principle seems to be, if you can get something for nothing and keep within the law, do it.

ECONOMIC STATUS

Even before the depression his income was steadily declining. Why? Time will not permit of more than a cursory enumeration of changes both within the profession and in society which have exercised, directly or indirectly, a marked influence on the economic status of the general practitioner.

I. *Changes within the profession affecting the general practitioner.*

1. The overdevelopment of the specialties both per se and in public opinion, which now visualizes a special type of service for nearly all forms of sickness.
2. The rapid development of hospitals with over-emphasis of their value as regards care and treatment of many diseases. In spite of the expressed opinion of the general practitioner that treatment at home is all that is indicated, the patient often times deems it necessary to enter a hospital, though it requires a journey of some distance to reach one.
3. Overproduction of physicians and their primary desire to locate in cities which already are over supplied, a situation which forces some to locate elsewhere, usually the selection being a town with an adequate number of general practitioners.
4. Too frequent failure on the part of specialized medicine to ethically support the general practitioner by referring back to him patients for such treatment as he is qualified to give and is entitled to. This situation brings into strong relief the fact that the voluntary, unscrutinized public assumption of the apellation "specialist" is not justified if such a one is in reality relying on medical fields extraneous to his specialty for support, an example of one of the uncorrected evils within the profession which directly affects the public and

which must be rectified sooner or later.

5. Contract practice, which is affecting primarily the interests of some general practitioners in cities.
6. Failure of organized medicine to grasp and look squarely in the eye and solve, once and for all time, the problem of the economic as well as ethical features of the relationship which should exist and become tractionally and uniformly imperative between the general practitioners and the specialists.
7. Failure on the part of some general practitioners to appreciate the absolute necessity of keeping fully abreast of the times in a medical way through study, attendance at medical societies, and postgraduate clinics.
8. Failure of organized medicine itself to provide proper postgraduate clinical instruction for the more or less isolated general practitioner, passing to him in an understandable way the newer things in diagnosis and treatment.

II. *Some changes in public thought affecting the general practitioner.*

1. Dissemination of knowledge by the press that health is an asset which should be looked after only in an up-to-date, scientific way, with the implied inference that this is often beyond the ability and facilities of the general practitioner, whereas he is fully capable of treating properly 90 per cent of the ailments with which his clientele may be afflicted.
2. The lowering of the morale of an ever increasing number of citizens through the insidious spread of the doctrine that it is no longer a social stigma to fail to remunerate physicians for their services, as one can go to public hospitals and have even better services for little or nothing. And that, in fact, the time is coming when the state itself will give everyone free medical care, a pauperization plan par excellence.

III. *Public Health activities, federal, state, county, municipal,—professedly scientifically preventive in their inception but which, wittingly or unwittingly, have steadily encroached on the domain of the private practitioner.*

Public health is rightfully a matter of such concern to the state that the medical profession must forever be subject to its control and direction. The extent to which supervising measures may be applied should, and I believe will, be inversely proportional to the demonstrated capacity of our profession to cooperatively serve the health interests of the Public in a satisfactory way.

IV. *Agencies which are of a semi-public or philanthropic nature:*

Anti-tuberculosis society.
Red Cross society.
Public Welfare
Child Welfare.
Maternity Welfare.
Venereal Clinics.
Association for crippled children.
Etc., Etc.

Whatever real or fancied grievance general practitioners of medicine may have with the activities of one or all of these agencies which society has evolved in its humanitarian desire to ameliorate the sufferings and handicaps of the afflicted, candor compels the admission that many of the measures which are under criticism have been due to our own lack of initiative both in offering better solutions and in the presentation of plans for their execution. Not one of these activities but what requires the services of the physician. He alone is the vital cog in whatever machinery is set up.

As expressed by the Committee on Medical Economics of the New York State Medical Society:

"If the physician is to hold his place in organized society, there must be a better planned unity and continuity of thought among doctors. There must be clearer orientation within the profession and between

medicine and society. Society is in the process of advolitional growth. Economic readjustments, in particular, are in the making. We have a responsibility to shape that growth.

"If collectively we shirk that civic-social obligation, we individually shall suffer loss of economic security and justice. We must choose to play a master part in the community life or accept the humble servant's lot. There is no middle ground."

If our profession continues to be as individualistic as it has in the past there will indeed be a forlorn and desperate outlook for the general practitioner, with the assured prospect that society will not hesitate in the future, any more than she has here-to-fore, to put into effect other measures when the ever increasing complexity of our social life presents the apparent need. Many villages in Wisconsin are without resident physicians. The number will probably increase. Society asks, Why? The medical profession answers, because:

1. A resident physician could not make ends meet.
2. The average graduate of today is over educated and will not elect to practice in a village environment.
3. The population is shifting, reducing the population of many villages to a point where they can no longer support a physician.

These, and other problems, will continue to vex society and our profession until solved. Would not a periodic meeting of all minds concerned with the health interests of society facilitate the best solutions?

NEED FOR CORRELATION

If we had in this state a voluntary Bureau of Correlated Health activities composed of the permanent secretaries, the active and past presidents, and the councilors of the various societies dealing with the subject, can anyone doubt that irritations and conflicts due largely to failure of understanding of the motives for given actions would not be done away with through argument and compromise? That as new problems arose or old ones were reconsidered some pattern of action would be evolved which could not fail to embrace in its design the guiding influence of the medical profession? Where could more aid be obtained in the furtherance of measures, legislative or otherwise, designed primarily to protect the public and secondarily to aid the general practitioner?

For example, a census of the indigent sick could be made through the joint efforts of the Board of Control and the medical profession, with a compromise estimation of the fair share of the burden of proper hospitalization and medical care which society should carry through taxation.

A mutually acceptable and beneficial policy of sympathetic constructive cooperation of all members of our Society with the State Department of Public Health could be evolved.

Our consultative advice, as socially minded citizens, might conceivably be gratefully accepted on problems not necessarily directly connected with our profession. Whatever the future problems of Society are, we must do our part, not only as individuals but as a profession, to help solve them. A program looking to the future adequate but not over supply of physicians in the state could be prepared in conjunction with the Deans of the medical schools and the State Board of Medical Examiners.

FUTURE PROGRAM

Knowing what we do about the problems of health presented by the population of this state, does not common sense dictate for the future a carefully considered program embracing the interests of all?

A survey reveals an abounding wealth of organized effort on the part of society and the medical profession to give an ever better type of service for the sick.

While we are but living in the third generic paragraph of the history of this state, all the factors necessary for proper solutions of the problems are already in existence.

Let me enumerate:

1. *Physical Equipment:*

In the past twenty years there has been such a development of modern hospital

facilities in various sections of the state through the philanthropic action of its citizens that Wisconsin may well raise her head in pride and point to the splendid institutions within her confines, staffed by skilled specialists and nursing personnel, which provide many hundreds of beds for the afflicted in the cities of their location and their surrounding territories.

A generation ago it was only in large centers of population and wealth that physicians could acquire the training with access to adequate hospital facilities, which would insure their growing skill and reputation as specialists. Patients living in distant rural districts, villages, and small cities were obliged to accept local services, often of an inferior quality, if financially unable to travel to metropolitan cities for aid. The truly remarkable change which has occurred in this state is scarcely understandable to those who have not taken part in it.

This epochal advance in the method of insuring the best type of service for the afflicted in an agricultural state owed its inception to the spark of individual genius in the mind of Wm. J. Mayo, whose conception of rendering just as high a type of service to the afflicted farmers and villagers in his sphere of influence as could be obtained in the metropolitan centers, served as a stimulating influence in this and neighboring states. So that it may be truly said that the character of medical service in this mid-northwestern section of the United States has been raised to a level far above that provided by any civilization past or present for a similar population of small cities, villages, and rural districts. As regards the indigent sick afflicted with rare, unusual, and complicated diseases, is there not a great central State Hospital which should serve as a clearing station for them? As regards the affluent, if they are not content with private hospitals and medical service within the state, do they not have easy access to nearby medical centers?

2. *Philanthropic Agencies.*

What finer expression of a civilization could be desired than the fact that the list of altruistic public and private social agencies in this state has reached its present proportions?

3. *General Practitioners of Medicine.*

I have lived in an atmosphere of medicine and surgery since boyhood. During an active career of thirty years, I have come to know intimately hundreds of general practitioners of medicine living in villages and small cities—men whom I hold in the highest esteem and regard for their intense love of their profession and their inherent honesty and probity in their relations with their patients. Physicians whose diagnostic ability, developed through years of bedside experience, is of the highest order; men who know something of everything, from taking a cinder out of an eye to treating ingrowing toe nails. General practitioners who have learned to use their powers of observation so that they can, without elaborate or costly laboratory instruments of precision, diagnose the great majority of human ailments and have a keen suspicion of what the remainder might be, with sense and honesty enough to direct such patients to a proper place to find out.

I question whether any state in the union has a higher grade type of general practitioner than Wisconsin. The great problem which faces society in this state is that of replacing these men, when they pass on, with others equally good.

4. At the present time the death of 100 physicians is over compensated by the addition of 200 new physicians; and yet there is an ever increasing number of villages in this state without the services of a residential physician.

The graduates of the great metropolitan colleges of medicine who enter upon practice in Wisconsin do not desire to become general practitioners in villages. How shall we meet the steadily increasing appeal of the inhabitants of these villages "Send us doctors, men who will be glad to live with us—to become part of us"? Obviously, only by such a special type of medical education as will produce them. The essential requisites in the making of a general practitioner for village practice are:

1. A village or farm boy who wishes to

become a doctor and who is encouraged in his ambition by the village doctor.

2. Measures to insure that he will not be so over educated that he will lose his desire of becoming a village doctor.

The best way to do this is to keep him under the influence of general practitioners of medicine during his senior and internship years,—a preceptorship system already established in this state which should, through the utilization of the available teaching ability and hospital facilities, be in many ways equivalent to and compensate for the lack of the many extra buildings, equipment, and personnel, running into many millions of dollars, deemed necessary for a metropolitan medical school.

For such a system to function properly and continue there must be not only the will to function on the part of the hospitals in which the preceptorships are placed; but there must also be, on the part of the capable, experienced physicians and surgeons who have suitable services in these institutions, an ardent, continuous cooperative desire to give freely of their time and services.

The continuing success of this experiment in state medical education hangs on a very tenuous thread which can be strengthened only by action on the part of the state. Such action as will evidence its recognition that these institutions are not only entitled to and worthy of financial aid through changes in the laws regarding the hospitalization of the local indigent sick, but that a continuation of the policy of the state itself entering into open competition with these institutions for the type of patient who is affluent, must cease.

In the words of William Gary Morgan in his speech to the House of Delegates of the American Medical Association:

"When a hospital is owned or operated by the government and supported by taxation to which the medical profession contributes its due proportion, medical attendance should be paid for by taxation along with the other facilities supplied by the institution. No hospital instituted and supported by public philanthropy or community cooperation of any kind should be permitted to increase its revenues, and so reduce its financial burden on the public, by any system of collecting fees for medical attendance, and thus engaging in the corporate practice of medicine.

"The membership of the Association should be guided by these principles in accepting posts on the staff of hospitals and should refuse to support, by the contribution of their services or by the reference of their patients, any institution violating them."

SUMMARY

I have tried to present a picture of the changes in this state which affect primarily the general practitioner of medicine but which if they continue must inevitably weaken the very warp and woof of the fabric of our profession. That part of the pattern of things as they are which already affects us in a deleterious way has been woven by well meaning but at times illy advised agencies of society in a zealous effort to ameliorate the physical sufferings of mankind. We have been too busy as individual practitioners of the art of medicine to note the significance of changes until they are accomplished facts. An endless number of pages of the history of our profession in this state lie before us who are in fact the very sons and disciples of the pioneer physicians. What will be written on those pages should not rest entirely on the knees of the gods. If, as recently expressed in public by one high in state medical authority, the state and its servants have no right to refuse to sell its wares—medical or otherwise—to all who come to its counters, it is evident that we have already come to the point in the road where two branches immediately confront us.

One, upon which some members of our profession have already started, slopes invitingly but insidiously downward, is smooth and easy to travel on without guides or leadership. Without too obvious signposts it leads definitely but by easy stages to state medicine and the utter dissolution and oblivion of our profession as one unworthy of the heritage bequeathed to us by our predecessors throughout the ages. The subtle stages along this road are: First, to offer state services to the indigent, then to

the moderately well-to-do, and finally to everybody.

The other branch of the road is much more formidable—a steep ascent strewn with obstacles, necessitating ardous labor with the best of leadership and guidance, not intermittently but continuously, a leadership which will demand that every member give his ardent and cooperative support to all measures which will preserve the integrity, privileges, and emoluments of organized medicine to the end that:

Not only we of today, but our sons and disciples of tomorrow whom we are obligated under the Hippocratic oath to foster, guide and protect, shall not, as practitioners of the art and science of medicine in this state, be mangled on the rack of pseudosocialism or forced to witness the agonized writhing of the sacred spirit of medicine when the red hot branding iron of a communistic medical service is pressed upon her troubled brow.

Quo Vadis—O Physician of Wisconsin?

Fractures of the Ankle*

By MELVIN S. HENDERSON, M. D.
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Because it is of distinct advantage occasionally to reconsider and review time-worn subjects that nevertheless have within them potentialities for trouble, I shall consider, in the time allotted me today, fractures of the ankle, for they literally bristle with trouble. Platt, in placing the subject for discussion before the British Orthopedic Association in 1925, said: "It is thus an old chapter in the history of surgery which we are about to reopen, and, though our subject is a commonplace problem in surgical handicraft, classical in its antiquity, it appears strangely new as each succeeding generation comes fresh to its difficulties, often oblivious of the wealth of knowledge already bequeathed by the older masters."

For more than twenty years I have seen passing through the Section on Orthopedics of The Mayo Clinic a considerable number of patients afflicted with disabilities that followed fractures, and who might have had more serviceable limbs if prompt and efficient treatment had been instituted at the time the fracture was sustained and if the after care had been carried through to completion. It is only fair to say, however, that many of the poor end results were, all things considered, the best that could have been obtained. That old fractures of the ankle constitute a goodly percentage of these poor end results is proved by the fact that during the five years of 1925 to 1930, 122 patients have come to the clinic seeking relief. In this same period we have had an opportunity to treat eighty-two fresh fractures of the ankle, and the lessons learned from observing patients when end results were unsatisfactory have been invaluable. It is this type of recent fracture that I shall consider here. Neither old fractures nor talar (astragalar) fractures will be considered, although, strictly speaking, the latter should be included in fractures of the ankle. They are much less common as evidenced by the fact that Platt noted but four talar to 116 tibial and fibular types of fractures. Too meticulous analysis and classification of any subject may confuse and take away valuable props for the support of existing understanding of the subject. Ashhurst delved into the literature so deeply, reviewing and considering the original articles of former masters that he was able finally to establish that Pott described a type of fracture which does not exist. His article is invaluable from the standpoint of classification and mechanism of fractures of the ankle, but owing to its completeness is not of much comfort to the casual student. Almost all writers decry the use of a man's name to designate a disease or condition, and attempt to avoid it. Platt, in commenting on this matter, so far as fractures of the ankle are concerned, stated that it would be impossible in England to

* Presented before 90th Anniversary Meeting, State Medical Society of Wisconsin, Madison, September 9, 10 and 11, 1931.

abolish the term Pott's fracture, and defines as his conception of the term "those fractures of the lower three inches of the fibula which are accompanied by rupture of the internal lateral ligament or fracture of the internal malleolus, and in which there is the slightest degree of deformity at the ankle joint, either eversion only, or eversion combined with posterior displacement of the foot." Inasmuch as Dupuytren, fifty years later, described the same type of fracture, with even more accuracy than did Pott, Platt suggested that they be called Pott–Dupuytren fractures, a recognition on his part of the historic phase of the subject. The term is clumsy, however, and I have not the least doubt we will continue in America to call them Pott's fractures. Ashhurst credited Maissonneuve (1840) with being the first accurately to describe the common fracture of the ankle recognized clinically by Pott and Dupuytren. The term Pott's fracture is, it seems to me, so inseparably linked with the subject, and embraces in one word the anatomic types of fracture of the ankle, accompanied by the well-known deformity (55 per cent according to Platt) with eversion accompanied by, or without, posterior displacement of the foot, that its use should and will survive.

ANATOMY OF THE ANKLE JOINT

The ankle is a hinge joint made up of the inferior articular surfaces of the tibia and the fibula and their accompanying ligaments, forming a mortice into which fits the trochlear surface of the talus. The trochlear surface is 25 per cent wider in front (fig. 1) than behind to conform with the shape of the mortice formed by the tibia and fibula. This arrangement makes it practically impossible for the talus to dislocate posteriorly unless the mortice is broken and prevents the bones of the leg from slipping forward off the talus when the person walks. The talus has no muscles attached to it; it is a rocker, or sort of a ball, on which glide the bones of the leg in anteroposterior motion, and inferiorly its articulation with the os calcis permits lateral motion. The lower ends of the tibia and fibula are held together by the thickened interosseous ligament, and by the well-developed anterior lateral malleolar ligament (anterior inferior tibia-fibular ligament) and by the posterior lateral malleolar ligament (posterior inferior tibia-fibular ligament).

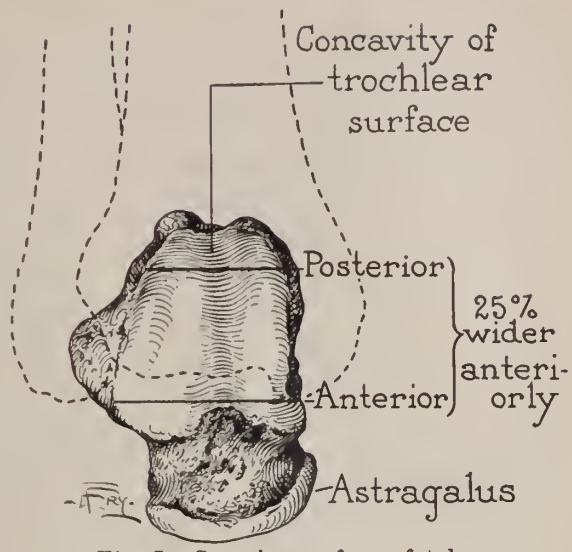

Fig. I. Superior surface of talus.

The foot is attached to the bones of the leg by ligaments, the best developed of which is the lateral. All are important, but of most importance so far as fractures of the ankle are concerned is the strong posterior

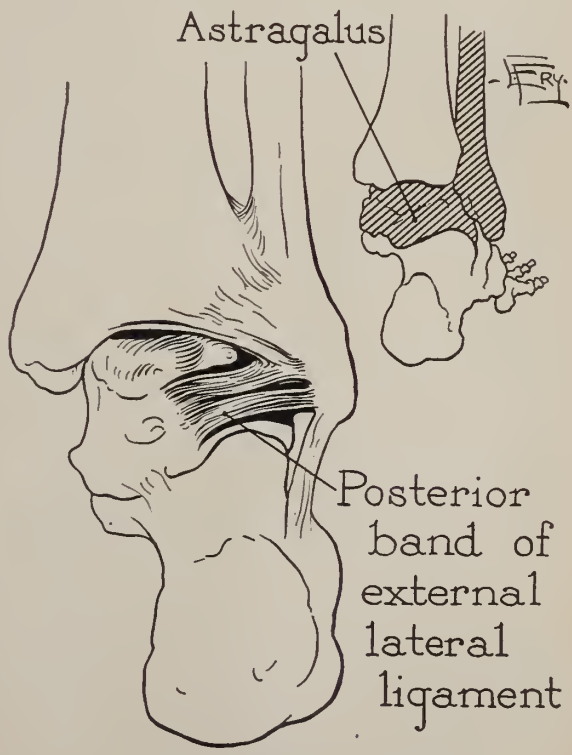

Fig. II. Diagrammatic representation of astragulofibular ligament.

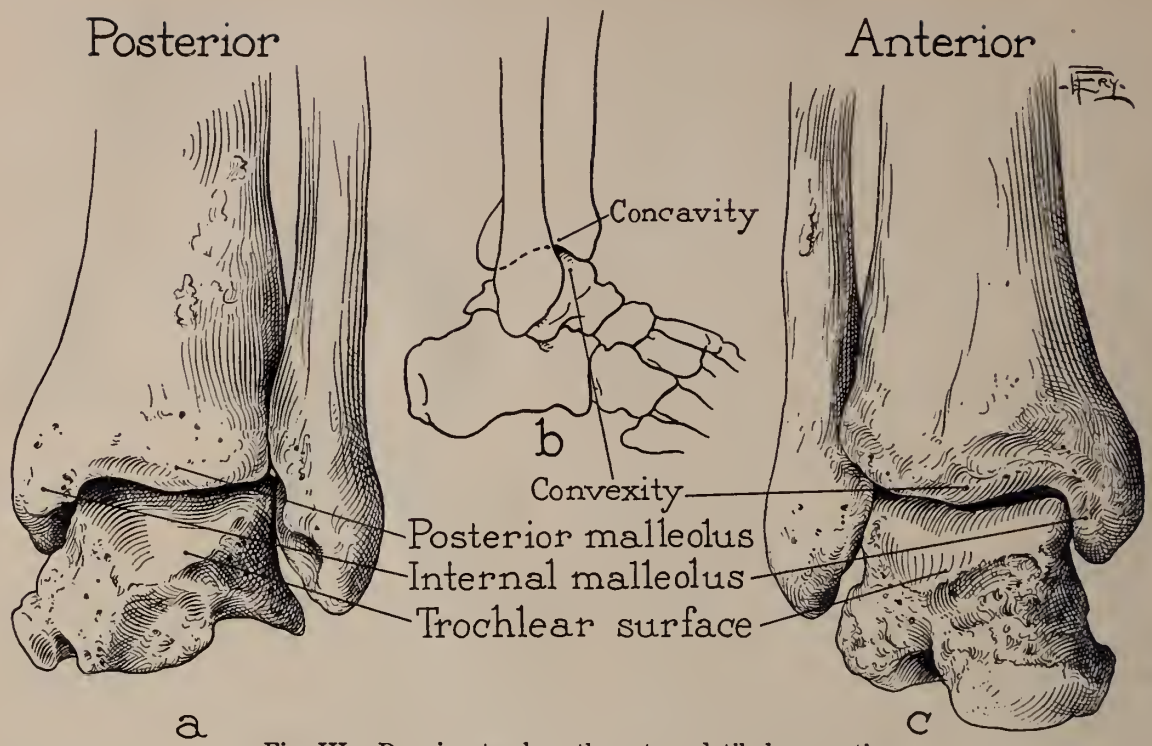

Fig. III. Drawing to show the astragulotibular reactions.

talofibular ligament (posterior band of the external lateral ligament) because of its attachment to the lower end of the fibula and to the posterior surface of the talus (fig. 2). This ligament practically never ruptures, which explains why the talus follows the lower end of the fibula in its displacements incident to the fractures under consideration. The articular tibial surface is known as the roof or ceiling, and the articular surfaces of the malleoli have been called "the cheeks of the mortice." Another anatomic condition that deserves more attention than it has received is that the posterior margin of the tibia or lip of the roof projects so low as to deserve the name of "posterior malleolus" (fig. 3*a*) applied to it by Destot, and explains at least partially why a posterior marginal fracture is so common. It would be well to consider the posterior margin as another malleolus and look as closely to its continuity as we do to either the internal or the external malleolus in studying roentgenograms of fractures of the ankle. In Ashhurst's 300 cases there were fifty-eight (19 per cent) of posterior marginal fractures, an astonishingly high ratio.

One must be thoroughly familiar with the bony components of the ankle joint as disclosed in roentgen-ray films of the normal ankle. In a direct anteroposterior view of the normal ankle it may be noted that the lower tibial articular surface has in the median line, a convexity downward which fits into a slight concavity in the trochlear or upper surface of the talus (fig. 3 *c*). In a side view of the normal ankle, the convexity of the trochlear surface of the talus fits into a concavity on the lower end of the tibia (fig. 3 *b*). If concavity and convexity fit each other in both views, the mortice of the ankle is as it should be and weight bearing will be carried out normally. After a fracture of the ankle has been reduced roentgenograms should be made (there must be excellent reasons for not doing so) in anteroposterior and in lateral directions; if the convexity of the tibia fits into the concavity of the talus in the anteroposterior view, and if the convexity of the talus is seen to fit into the concavity of the tibia in the lateral view, all is well. If not, one must beware!

MECHANISM OF PRODUCTION

Direct violence rarely is the cause of fractures of the ankle, only 1 per cent according

to Ashhurst. Authorities are pretty much in accord as to the types of forced movement (indirect violence) of the foot by which a strain transmitted by way of the talus may be sufficient to fracture the lower end of the tibia, of the fibula or of both. They are: (1) external rotation, (2) abduction (eversion), (3) adduction (inversion), and (4) compression.

External rotation.—The foot is rotated outward around the vertical axis of the leg, and the force is transmitted through the talus to the fibula as a torsion strain, resulting in an oblique fracture running from above downward and forward. Rupture of the lateral malleolar ligament is uncommon; hence diastasis is rare. Usually the force stops here, but if it is continued, the next step is a tearing of the deltoid (internal lateral) ligament or a fracture of the internal malleolus.

Abduction (eversion, fibular flexion).—Since the force causes the talus to be everted, the first structure to give way is the deltoid ligament, or the internal malleolus itself. Then the fibula gives way either below the level of the inferior tibiofibular junction (malleolar), or through the slender portion above the malleolus, sometimes referred to as the surgical neck. Diastasis is rare in the former circumstances but common in the latter circumstances.

Adduction (inversion, tibial flexion).—With this type of indirect violence the external malleolus tears off and the thrust of the talus against the internal malleolus causes fracture of that structure.

Compression.—Weight borne on the injured limb immediately after the fibula is fractured is significant in the production of injuries to the articulating lower end of the tibia. Falls from a height may cause bizarre and unusual fractures of the tibial weight-bearing end such as the *Y* and *V* types. Diastasis is common and the fibular edge of the tibia may be so injured as to render repair difficult, and convalescence is slow and prolonged.

CLASSIFICATION OF FRACTURES OF THE ANKLE

Ashhurst expressed himself in favor of a classification based on the mechanism by which the fracture is produced. He designates them as an external rotation, abduction, adduction and compression fractures, but "for the sake of completeness" he grouped his cases also under an anatomicophysiologic classification. It is not always possible to obtain from the patient information as to the exact manner of the force which produced the fracture; thus, in using a classification based on the mechanical force, one must often deduct from the lesion present just how the fracture was produced. I am in favor of the anatomicophysiologic classification as originally developed by Tanton, and I offer the modification of it given by Platt, and later by Dickson (tabulation).

FRACTURES OF THE ANKLE

ANATOMICOPHYSIOLOGIC CLASSIFICATION (TANTON)

	Cases	Per cent
A. Fracture of the malleoli		
1. Isolated		
a. Fibula	25	30.7
b. Internal malleolus	12	14.6
2. Combined		
a. Low bimalleolar without displacement of talus	10	12.1
b. Bimalleolar with displacement of talus (Pott's)*	21	25.6
B. Fracture of weight bearing surface of the tibia		
1. Isolated		
a. Posterior margin	3	3.6
b. Anterior margin	4	4.8
2. Combined		
a. Anterior or posterior margin fracture associated with fracture of the malleoli (Pott's and "trimalleolar")	7	8.5

In either isolated internal or external malleolar fractures there is no talar displacement, the latter resting in the mortice in normal manner.

Fibula.—The isolated external malleolar fracture is produced by external rotation; it is usually spiral and the upper limit of the fracture is higher posteriorly (fig. 4 *b*).

* Pott's fracture, the most common fracture of the ankle, includes several of the anatomic types and does not fit into any classification. The term has been used so long that it should be retained to designate the fractures of the ankle with eversion alone, or combined with posterior displacement of the foot. Pott's description was based on clinical observation only.

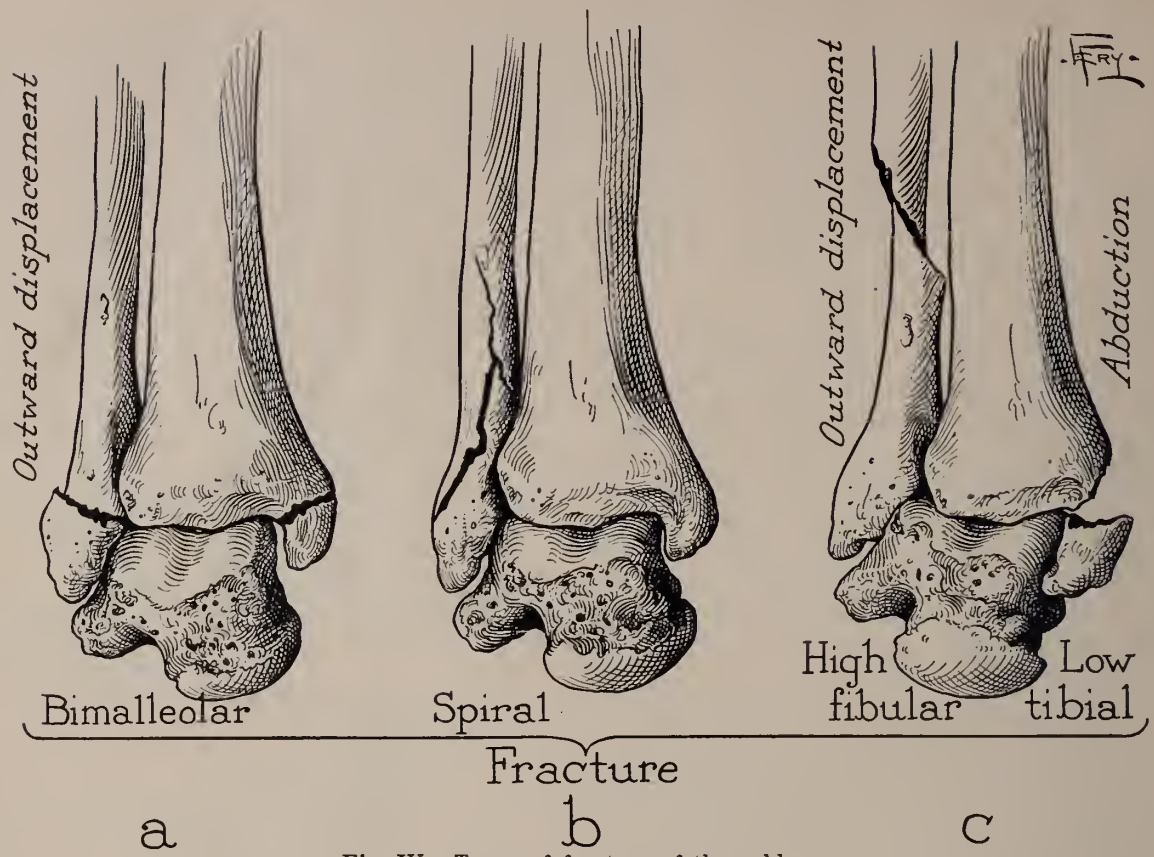

Fig. IV. Types of fracture of the ankle.

There is no displacement of the foot. Rest and fixation in a cast for ten to twenty days, depending on the amount of ecchymosis and swelling, is indicated, and also massage followed by active and passive movements. Swelling and tenderness, with some disability, may persist for several months, but the final result is always good and operative interference is never indicated.

Internal malleolus.—The isolated fracture of the internal malleolus follows adduction violence. The internal malleolus is usually only slightly displaced and the foot is not out of position. However, the displacement of the fragment may be sufficient to be noticeable, and rather than accept a permanent unsightly deformity one should cut down on such a fracture without hesitation, and sew the fragment in place or peg it with a beef bone screw.

Low bimalleolar without displacement of talus.—Bimalleolar fractures in which the lines of the fracture are through the malleoli at the level of the talar tibial joint are common. There may be no talar displacement, and fixation in normal position is all that is necessary in the way of treatment, but active motion and massage should be started early.

Bimalleolar with displacement of talus (Pott's).—When, with the bimalleolar fractures the talus is displaced outward (Pott's fracture), care must be taken to see that accurate reposition is obtained, for even slight displacement may lead to serious, prolonged and often permanent disability. Reduction must be accurate, not always an easy matter in this type, due to laxity of the parts (fig. 4 *a*). Extreme care is necessary in application of the cast and that reduction is complete should be verified by roentgen-ray examination through the cast to see that the talar tibial contours are normal.

Posterior margin of tibial surface.—Occasionally the posterior malleolus (posterior margin of tibial surface) only is fractured, and the fracture can be detected only in the roentgenograms taken from the lateral aspect. Posterior displacement of the foot rarely, if ever, is present. Treatment con-

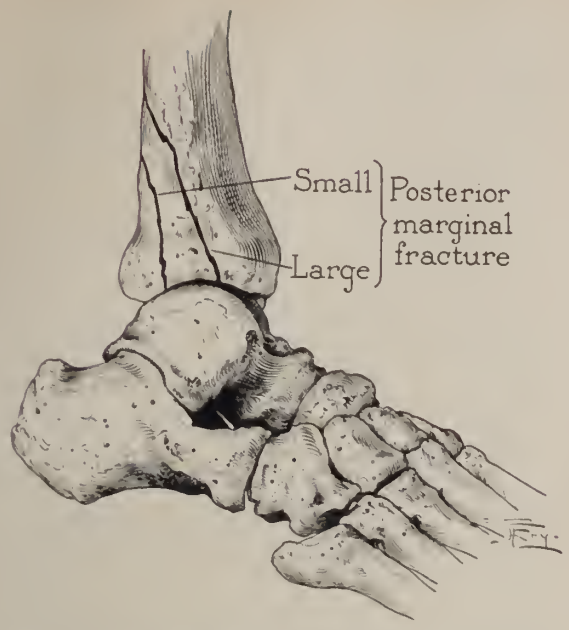

Fig. V. Diagrammatic representation of posterior marginal fractures without displacement.

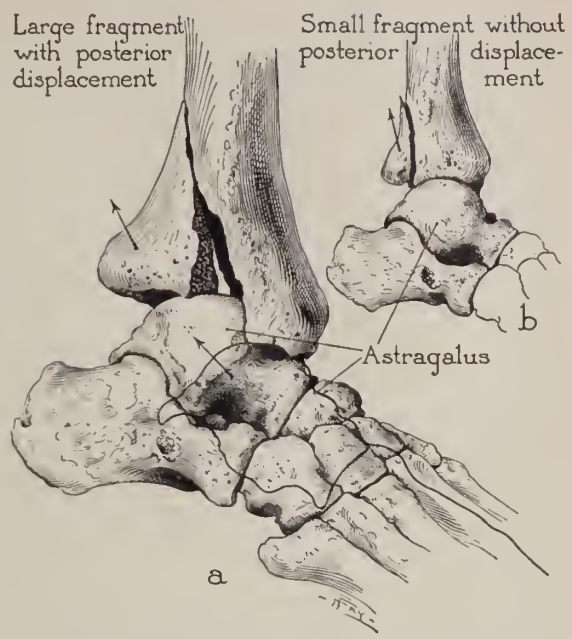

Fig. VI. Fracture of tibia with posterior displacement of foot.

sists of placing the ankle in normal position in a cast for sixteen to eighteen days. Early motion is indicated, and no weight bearing for six weeks. Some tenderness will persist for a considerable time, particularly on going down stairs or walking down hill because the weight is thrown more directly on the line of fracture.

Anterior margin.—Isolated anterior marginal fractures are rather rare and are not of so much clinical significance as the posterior marginal fracture, because the talus is not displaced with it. The fragment is usually small and seldom requires any direct attention.

Fracture of internal malleolus and fibula (surgical neck).—The deltoid ligament may be torn from the internal malleolus or the internal malleolus may be fractured and the fibula may be fractured 5 or 7 cm. higher (fig. 4 *c*) at its narrow portion, with consequent lateral displacement of the foot (Pott's fracture). There may appear to be some posterior displacement of the foot due to giving way of the anterior lateral malleolar ligament, which allows the lower end of the fibula to roll outward, and with it the talus. Actual posterior displacement of the foot, without posterior marginal fracture may occur, but it must be very rare.

Trimalleolar fractures.—These are posterior marginal (malleolar) fractures associated with fracture of the internal malleolus and lower portion of the fibula. Fractures of this kind are too often unrecognized, or inadequately reduced, leading to serious disability. Dupuytren and Astley Cooper describe such a fracture and it has been discovered on numerous occasions since then. Cotton, several years ago, again called attention to it and it has been spoken of at times as Cotton's fracture. It rightfully belongs to antiquity and is an example of how carefully garnered knowledge is allowed to be more or less forgotten, remaining so until rediscovered by some keen observer. If we accept Destot's term "posterior malleolus" to designate the posterior margin of the tibia we might speak of this type of fracture as "trimalleolar." Trimalleolar has the merit of brevity and is descriptive although in some cases it may not be anatomically correct in the strict sense, for the fibular fracture is more often in the constricted surgical neck 5 to 7 cm. above the tip than in the malleolus, itself. It would serve to impress on all the necessity of always scrutinizing in the films the posterior lip of the tibial articulating surface. Such fractures are the result of compression violence, the

talus transmitting the weight in such a manner against the posterior malleolus as to cause a longitudinal fracture carrying with it varying amounts of the tibial shaft (fig. 5). When the posterior malleolus gives way, the talus, and with it the foot, is displaced posteriorly and if the reduction is not complete the weight-bearing articular surface is distorted. If the posterior fragment is small (fig. 6 *b*), and there remains anteriorly enough of the normal articular surface of the tibia to catch and hold the convex talar articular surface after setting, the reduction may be readily maintained. On the other hand, if the posterior fragment is large (fig. 6 *a*) and the remaining anterior concave tibial surface is too small to hold the convex talar surface and most of it rests on the posterior fragment, the normal muscle pull will put such force on that fragment that it will be displaced upward and posterior displacement of the foot will recur (fig. 6). The amount of compression force or violence sustained in these fractures determines the amount of comminution and injury sustained by the lower articular and weight-bearing end of the tibia. Great fragmentation and diastasis may occur, ends of bone may be driven through the skin, and the fracture may become compound.

CLINICAL CONSIDERATION

A high percentage of fractures of the ankle are associated with little evident deformity, and it may be difficult to elicit crepitus. Too often a diagnosis of sprain is made, and hence the necessity of resort to roentgenograms in injuries to the ankle. Pain, disability and swelling following injury of the ankle demand careful inspection and consideration. Sharply localized tenderness is commonly present over the site of fracture and is an important finding. It is not necessary to consider in detail the clinical picture of fractures of the ankle, for the disability, eversion, and so forth is so familiar to all. Particularly it must be remembered that the sometimes extensive swelling that comes on shortly after the injury may mask and conceal even considerable bony displacement.

Treatment.—Reduction of a fracture of the ankle should always be done under anesthesia. Complete relaxation is so necessary to eliminate the combative spasm of muscles that to attempt to reduce these fractures without it is only to court failure.

The end results of the treatment of any particular type of fracture in the final analysis control the methods that are to be used. If conservative measures give satisfactory results, there can be no brief for operative measures. I think it can be stated without fear of contradiction, that the consensus of opinion today is that conservative measures give in the main, satisfactory results in fractures of the ankle, and that open operative treatment should be reserved for exceptional cases only. If operation must be undertaken it should be done early. Delay only increases the difficulty, and if days or weeks are allowed to elapse it may be impossible to secure anatomic reduction. In my experience there is one particular type of fracture of the ankle joint that demands open interference. This is what I previously referred to as the trimalleolar or posterior marginal fracture wherein such a large fragment of the posterior portion of the tibia is broken off that if reduction is attempted by the closed method there is not enough of the articular surface of the tibia left intact to hold the talus in the mortice (fig. 6). Therefore, approach should be made from behind, the tendo achillis divided by the *Z* method, and the fragment replaced in perfect position and held in place by pegging either with beef-bone pegs or beef-bone screws. In this way the weight-bearing surface is kept smooth.

Stages of treatment.—Control of the treatment to completion is essential for satisfactory results. The treatment may be divided arbitrarily into four stages: reduction, retention, mobility, and weight-bearing.

Reduction is to be accomplished after a thorough understanding and knowledge of the lesion present in each case. The earlier the reduction is undertaken the better, if possible before swelling starts, and, as a matter of fact, if reduction is accomplished early and the part subsequently elevated,

there will be little if any swelling. Too great emphasis cannot be placed on the point that after reduction is accomplished, roentgenograms should be taken to see that reduction is complete. The talus must fit accurately into the mortice of the ankle joint, as shown by satisfactory roentgenograms taken from the anteroposterior and from the lateral aspects.

Retention after reduction is just as essential as reduction. There is no question but that plaster of paris affords the best means of maintaining the fragments in the reduced position. The cast should be smoothly and evenly applied, the heel should be held firmly in the position desired, and the front part of the foot should be held up to prevent equinus deformity.

Motion should be instituted as early as possible. It is my custom to begin motion by the second or third week. Massage by the various measures such as heat, may be used also, but active motion is the most important. With the leg held out of the bivalve cast and the muscles relaxed, the patient is encouraged to dorsiflex and plantar flex the ankle, and it is surprising how easily and painlessly this active motion can be carried on. Passive motion must be used gingerly and carefully.

Weight bearing should not be permitted for at least six weeks. Roentgenograms should be taken to be sure that the fragments are still in proper position and that bony union is firm. Patients who have experienced poor end results often volunteer the information that up to the time they were allowed to bear weight, the ankle was perfectly straight but that it soon became crooked after walking. Therefore, it is extremely important that weight bearing should be controlled, and especially if patients are heavy, provision should be made for some support. A shoe should be provided with the sole and heel elevated on the inner side so as to throw the weight on the outer side of the foot, and for heavy people, an inside *T* strap and an outside iron should be provided to prevent eversion strain. The length of disability varies with cases. Platt stated that the average period of full incapacity is fourteen weeks; this agrees with my experience.

Recovery often seems slow; patients will complain bitterly of pain and disability and one wonders whether this will be permanent, but I have been surprised on seeing these same patients a year or so after treatment to find them with normal ankles.

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Arthritis of the Spine With Reference to Industrial Accidents*

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The subject of chronic arthritis of the spine is a very wide and voluminous one. Time will not permit me to discuss chronic arthritis in any detail in this paper, nor will it permit me to take up all the different types of chronic arthritis of the spine, so I am going to limit myself to the type of chronic arthritis that has so commonly come under my observation in handling numerous industrial patients.

Reasons for presentation:

1. The number of back injuries encountered in industrial work.

2. The various degrees of disability resulting from these types of injuries.

3. A slight or inconsequential injury or strain to an arthritic back will result in

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partial or permanent partial disability out of all proportion to the amount of damage sustained.

4. Normal or even anomalous spines without arthritic changes do not suffer the prolonged convalescence or the residual damage that an arthritic spine does. This point has been emphasized recently by Chusway and Maier (1) and Bohart (2) in J. A. M. A., 1929.

5. Reasons, other than trauma, for this amount of disability must be looked for elsewhere. This is frequently found to be a predisposing pathological condition of the spine, as recent reports in literature and surveys show. (1, 2, 3, 4, 5.)

6. When the causative factors are evaluated properly, mainly trauma, infection and metabolic changes, just compensation can be offered which applies to both the individual and the industries.

Before the recent compilation of facts, and results of surveys and the accumulation of reports in literature, there were many cases classed as malingerers who were treated as such, and who undoubtedly belonged in this class of chronic arthritics. No doubt there are many present who recall cases of this type and the previous attitude assumed toward them. They were pigeonholed as malingerers and unjust handling of their cases as sometimes seen.

The importance of the condition of spinal arthritis in industry has been emphasized by Louis W. Allard (3) in November, 1929, in a paper based on his own experience, reinforced by a questionnaire addressed to industrial compensation boards and to leading orthopedic surgeons. The consensus of opinion received from compensation boards was that there are a large number incapacitated from back injuries other than fractures, in which the leading symptoms indicate some form of arthritis. However, the records are confusing and incomplete, because medical reports are not made in terms of disease, but of trauma, and the common tendency is to attribute all of the disability to trauma. *This indicates that a more general agreement among reporting surgeons as to terms and ideas of underlying pathology is necessary before statistical information of value may be obtained from this source.* From this comprehensive study Allard concludes:

1. Spinal arthritis in its various types is a common affliction of adults, especially the laborer.

2. Extensive arthritis of the spine may be found without symptoms.

3. Symptomatic arthritis in its incipience is without roentgenologic evidence.

4. The discomforts and disabilities from spinal arthritis in industrial injuries is largely due to a disturbance of the partially fused joints.

5. Arthritic subjects are prone to more or less disability from injuries that would not affect a normal person.

6. Disabilities complicated by arthritis occasion a longer convalescence than disabilities occurring in normal spines.

7. The victim of well established spinal arthritis is not a normal man. His efficiency is lowered. He is awkward and often distracted by discomfort, easily fatigued, and an easy prey to minor accidents. He is an industrial hazard.

8. Patients with recognized arthritis, properly advised, may be preserved for years of usefulness, with a big saving to industrial insurance.

Allard's conclusions adequately sum up the recent views on spinal arthritis and its relation to back injuries. Before considering the subject any further a brief consideration of spinal arthritis as to etiology, pathology and classification and its general relationship to chronic arthritis would probably fit in very well and give better understanding of the problems confronting us.

Chronic arthritis of the spine, speaking generally, is a local manifestation in a specialized part of the body. The characteristics of this disease are dependent upon the functional and mechanical peculiarities of the spine. Arthritis must be considered as a general condition mainly noticeable in the joints, but in which many of the other tissues of the body are involved.

CLASSIFICATION

I have taken the classification as that made by Goldthwaite, (6 & 7):

1. Atrophic arthritis.
2. Infectious arthritis.
3. Hypertrophic arthritis.

Atrophic arthritis is characterized by marked atrophy of the bone and joint structures with similar atrophy of the muscles, blood vessels and practically all the tissues of the body. The disease is seen most commonly in the slender type of individual and since this type has increased markedly in the past generation, it is natural that this type of disease be more prevalent than it was a generation ago.

Atrophic arthritis, which is the most disabling of all types, may occur at any age, but is most common between twenty and forty years of age, and while both men and women have the disease, women probably outnumber the men three to one.

Infectious arthritis, which is the least common of the three, and which may be seen in any of the anatomic types, the slender, the intermediate or the heavy, is due to absorption of microorganisms or their products from other parts of the body. As far as can be determined, no one organism is responsible for all of these cases, but any organism may at times become more active systemically, with joint or bone symptoms resulting.

Hypertrophic arthritis: This type of disease is characterized by an increased density of the articular cartilage and the cancellous bone adjacent to the joints with outgrowths from the edges of the cartilages, the common spurs or nodes, and at times similar growths or deposits at the attachments of muscles or fasciae.

This disease, while much less general as far as joint manifestations are concerned, frequently showing for long as a monarticular process is, nevertheless, a general disease with characteristic general symptoms. Instead of atrophy, hypertrophy or greater density of the tissues is the essential characteristic. Hypertrophic arthritis is seen most commonly in those having the stocky or heavy anatomic build, and is most common past forty years of age. The progress is less rapid than the atrophic type and leads to much less disability.

This is the type that I am discussing in my paper, and in whom the pathological findings vary from small nodes to large spurs and sometimes fixation of several vertebrae by these new formations, and yet find a patient who has not made any complaint of his spine.

In this type, a degeneration of the cartilage occurs in the joint, osteochondral proliferation and large synovial projections sometimes producing loose bodies in the joint. There is a primary fibrillation and softening with erosion of a portion of the joint cartilage. Irregular growths of bone and cartilage may occur, often with erosion in one place and compensating overgrowth in another. There is increased perichondrial activity and new formation of cartilage and bone, with irregular increase circumferentially. The joint is irregularly enlarged; there is periarticular thickening, but as a rule the synovial membrane is not involved, except at the periphery of the joint. Marginal bony proliferations and osteophytes occur and impair motion mechanically. Large synovial projections or pedunculated growths of connective tissue may produce loose bodies in the joints. Arrest may occur at any age. (11).

Etiology: May be classed as

1. Infectious.
2. Traumatic.
3. Compensatory.

These are the accepted causes of arthritis. When due to infection, as stated before, it is not necessarily confined to any specific type of infection and may be localized to one joint or may involve numerous joints at the same time.

When due to trauma it is, of course, necessarily confined to the area that is injured, and then depending upon the severity of the injury, will determine the degree of arthritis that probably will develop as a result of such trauma.

The third or compensatory cause, as determined by some German authorities, is that the injury is not necessarily a trauma to the joint or joint structures, but is the result of long continued muscular contraction upon the attachments of the muscle to the

bone thereby causing a chronic irritation and that trauma may sometimes only injure the muscle and cause temporary disability, but may in no way have any influence upon the existing hypertrophic arthritis.

Symptomatology: In more than eighty percent of the cases the condition comes on in the middle span of life, usually more frequently in the male. (5 & 13) The patient usually complains of a lame back, especially on arising in the morning; it may be stiff for some time before movement causes relaxation. As the disease progresses, the pain gradually becomes more and more aggravated by bending, straining, moving or riding. The patients move with considerable caution, getting up slowly from a chair by holding on to the arms, and walking with great care, and are often more comfortable sitting up than they are lying down. They do not seem to get entirely over this stiffness and eventually the pain becomes constant, especially in the lower dorsal and lumbar spine. The pains may be referred almost anywhere, sciatica or simulated sciatica being one of the common complaints. As a portion of the spine becomes ankylosed, the pain decreases in this part and is located in the more active region. The disease need not progress in this order, for there are not a few cases of primary cervical involvement. Any marked degree of this condition causes a lowering of the patient's general health and resistance. When the cervical spine is involved, slight movements of the head and neck become painful and the head may drop forward on the chest. The dorsolumbar regions are most frequently affected. When complete fixation of the spine occurs, the chest is fixed and predisposes to respiratory infections. Previously the different involvements of the spine were classed separately, but now the tendency is to consider them all a part of the same process.

Regarding spinal arthritis, and its relation to industry, in the last few years considerable literature has accumulated concerning the pathology existing in cases of injury to the spine and to the larger joints, in which the patient complains over a longer period of time than is usually required for recovery in similar cases. As x-ray technic improved, changes in the bones and joints were demonstrated which formerly were not suspected, and as these changes were manifestly acquired over a period of time, the question of responsibility of the trauma for the condition became acutely controversial in courts and before industrial commissions. As the number of cases increased, large groups were studied, opinion began to crystallize that the trauma is incidental to a previously existing disease, and is instrumental only in an aggravation of the symptoms which then persist indefinitely.

This opinion is probably fairly well established among those who are doing considerable industrial work, as examination of large numbers of spines, as well as other joints, by x-ray, reveals a surprising number of each sex who present definite changes in bone, cartilage and fascias, many of whom are entirely without symptoms until they get hurt.

Without a doubt, it is generally accepted that trauma, repeated strains, overwork, fatigue, exposure, are all predisposing factors in the production of arthritis. The laborer in whom this condition is most frequently found and who is most concerned is the one most subject to these factors. S. Miller, in an article on "Injuries to the spine as related to arthritis" (5) made an analysis of about five hundred cases to determine incidence of hypertrophic bone changes in relation to age and occupation, brings out the fact that these changes occur usually in people of active occupations and are increased directly proportional to the age. It is the wear and tear of their daily life that predispose them to arthritic changes. And, so far as arthritis of the spine and larger joints is concerned, all the work a man has ever done in his life, every year that goes behind him, has contributed its part to his physical condition at fifty, and it cannot by any stretch of the imagination be construed as an occupational disease, referable to any kind of work.

It would be a simple thing to institute so rigid a physical examination as to totally exclude from employment all but selected men, but whether it would be good business is another question. The industries must

bear their full proportion of consequences of wear and tear inflicted on the men they employ; the great problem is to have it bear equally on industry as a whole instead of on the particular enterprise that happens to be employing a man when his breakdown occurs.

The writer has made a careful analysis of a hundred cases, that have come under his observation, in which hypertrophic arthritis of the spine was found and in which the histories, at least, indicated that there were no symptoms prior to the injury. These patients were between the ages of forty and sixty. They also denied having had any rheumatic symptoms or neuromuscular pain. This would be interpreted to mean that these patients had bony changes, as shown by the x-ray, and that these changes were not the result of a true inflammatory arthritis.

In considering anatomical variations and anomalies of the spine and their relation to prognosis and length of disability, I wish to stress the poor prognosis in hypertrophic spines and the good prognosis and lack of disability in anomalous spines.

SUMMARY

Chronic hypertrophic arthritis of the spine is usually found in the laboring class and past the age of forty and is more commonly found in men than in women and is usually found without symptoms until some injury becomes engrafted upon it and precipitates disability. It may be found in any part of the spinal column, but is most commonly found in the lower dorsal and lumbar region. This is probably due to an anatomical basis. Trauma may aggravate an existing hypertrophic arthritis or may cause an insufficiency of the musculature and thereby cause disability.

In closing, I wish to emphasize the necessity of careful study of each case, not only by physical examination but roentgenological examination as well, in order to determine the condition that was old and had existed at the time of the injury and that which has been caused by trauma. In this way we can, to a reasonable certainty, determine what a man's disability should be and what part of this disability is directly the result of injury.

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A. C. S. AT ST. LOUIS

The twenty-second annual Clinical Congress of the American College of Surgeons will be held in St. Louis, October 17–21, with headquarters at the Jefferson Hotel. An instructive program of operative clinics has been prepared by the local Committee on Arrangements of which Dr. Evarts A. Graham is Chairman. Hospital standardization conferences under the direction of Dr. Malcolm T. MacEachern will be held during the first four days. Four special programs have been prepared dealing respectively with fractures, curability of cancer, industrial medicine and traumatic surgery, and the teaching of surgery and the surgical specialties. Medical motion pictures will be on daily exhibition.

Copy of the program for the St. Louis Congress may be obtained by addressing Dr. F. A. Martin, American College of Surgeons, 54 E. Erie St., Chicago.

Mixed Tumors of the Parotid Gland; A Study of Fifteen Cases*

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Mixed tumors of the parotid gland have been a subject for controversy among pathologists for a long time even though their clinical identification has been simple enough. Although they form a small percentage of malignant tumors of the body, yet their early recognition is important in order that the tumor may be removed while still encapsulated. At this stage the growth is usually small, may be excised with excellent prospects of cure, and with little danger of injury to the facial nerve. This nerve, because of its important facial distribution, usually is involved when the tumor breaks through its capsule and assumes invasive characteristics. Paralysis of the facial nerve results in a drooping of the corner of the eye and mouth and a flattening out of the side of the face. If the capsule is ruptured, the tumor may develop typical malignant tendencies and metastasize to the neighboring structures.

A number of excellent reviews of these tumors have appeared in the literature, and no attempt will be made to cover this subject in this brief discussion. The most recent of these communications is a study by Benedict and Meigs of 225 cases with complete end results in 85 cases from the Massachusetts General and the Huntington Memorial Hospitals of Boston. These records go back as far as 1872 and give an excellent idea of the final results of these cases.

In 1926 McFarland reviewed the cases from the pathologic laboratories of the University of Pennsylvania and the Philadelphia General Hospital and added 90 cases, together with 269 from the literature making a total at this time of 359. If the 225 cases previously mentioned are added to these, together with the 15 in this series, a total of 599 cases is available for study. Undoubtedly many more cases have been observed but not reported. If the diagnosis is to be established sufficiently early to permit a cure, it is essential that all the facts pertaining to the present status of these tumors be generally recognized.

The etiology of these tumors is unknown, but various theories have been advanced with regard to their origin. Volkman believes that they are derived from the endothelium of the blood vessels and lymphatics, and, therefore, should be classified as endothelioma. Da Costa holds this view, but emphasizes the fact that they cannot always be distinguished clinically from sarcoma. Some believe that they originate in fetal nests in the parotid, which are encapsulated and grow gradually. Wilson and Willius believe they are mesotheliomas. McFarland believes that the theory of "enclavement" or accidental sequestration of embryonal cells during the early and complicated development of the face and neck afford the most satisfactory explanation of the origin. Von Burns believes they are epithelial in type springing from the ducts or acini. Fraser believes they arise from the glandular structure of the salivary glands, principally from the ducts. They are thought by some to be carcinomas and by others basal cell epitheliomas. Ewing feels that no single source of the mixed tumors meets all the requirements.

The great number of theories and the marked difference of opinion regarding the origin of these tumors may be judged from this brief abstract. McFarland believes that his theory accounts for the number and variety of tissues found in the tumors, and for their varying proportions and conditions. He also believes they are individual entities, having no relation to the normal structures in which they occur, but from which they do not arise. They have nothing to do with other kinds of tumors, and should be called "mixed tumors" and nothing else, regardless of their histology.

The histologic picture of these tumors is usually complex-cartilage, fibrous tissue, or epithelial elements may be present and on this account their microscopic recognition is not difficult. The picture may show va-

* Presented before Alumni Meeting, Mayo Clinic, October, 1931.

rious types of tissue in the same tumor. From a review of his series McFarland makes the important observation that the *clinical prognosis cannot be determined by the histologic appearance of the tumor.* Patients, having tumors whose histologic appearance often suggests the highest degree of malignancy, have sometimes survived the longest.

The clinical diagnosis of mixed tumors of the parotid gland is as a rule not difficult. They may occur at any age, although are most frequent in the third and fourth decades. In the series here reported only six were under 50 years of age. The oldest being 67 and the youngest 7. These tumors occur equally in the sexes as shown in this group. They occur equally in the right or left parotid gland.

Some tumors are present only a few months, and then on account of their rapid growth are easily recognized. Others appear to remain dormant for many years, some cases have been reported in which the duration was thirty years or more. In this series a tumor had not been recognized for as long as a decade. On account of the slow growth of some tumors a certain number of patients delay operation fearing possible injury to the facial nerve. In the meantime the tumor which is at first a small painless growth may gradually enlarge, rupture the capsule and invade the surrounding structures. It is then that the facial nerve is often involved or must be sacrificed in the attempt to remove all the involved gland structure. There is but slight risk of injuring the nerve if the tumor is excised before rupture of the capsule, or before it has attained such size as to cause its excision to be technically difficult.

The smallest tumor in this series was discovered during the course of a routine examination, the patient thinking she might have a goiter. This tumor about 2 cm. was in marked contrast to a huge tumor about 6 cm. in the child aged 7 years. The former was easily excised with the capsule intact and the patient practically assured of a cure, while the latter was considered inoperable on account of its involvement by invasion of the vital structures.

Sistrunk has perhaps given the best description of the surgical treatment of this condition. He deplores the fact that many patients defer having the operation performed while the growths are small on account of possible injury to the facial nerve, and thus lose the opportunity of having it done at the time when the chance of cure is highest and the possibility of injury to the nerve is least. Because of this danger many patients are subjected also to an incomplete operation resulting in recurrence of the growth, and possible loss of life. If the capsule is ruptured during the course of operation there is a great tendency for these tumors to recur, one, five, or even twenty years later. It may be possible to excise the recurrence completely enough to effect a cure. Case 3 is an interesting example of such a condition. This patient, a woman aged 51, had been operated upon elsewhere seven years previously with a resulting partial facial paralysis. Three years after operation a recurrence developed. It did not seem possible to save the nerve in this case, but the fibers were preserved intact and freed of scar tissue and the involved area was thoroughly dissected. Today the patient has no sign of facial paralysis and is in perfect health two years after operation. This operation was followed up with heavy doses of radium.

SERIES OF CASES

In this series it was only necessary to sacrifice the facial nerve in two instances. Case 4, a woman aged 52, presented a very advanced malignant appearing growth of only five weeks' duration. Operation in this case was performed by my brother, James, and he found the capsule had already been ruptured and the entire gland involved. Although radical excision was followed by roentgen-ray therapy this patient lived only a few months.

Of the 15 cases in this group 10 were operated on with no operative deaths, 2 patients have since died, and 8 are still well with no evidence of recurrence to date. Of the 10 cases operated on the capsule was intact in only 6. It is reasonable to believe that the 2 patients who died might have been saved

if surgery had been instituted before rupture of the capsule. When one considers that the tumors in this group were present on an average of more than three years, it is apparent that a lowered mortality might have resulted from early recognition and treatment. While these tumors are not as highly malignant as some: for example, tumors of the breast, nevertheless they should be considered as a potential source of danger and treated as such.

We have found it possible to remove all but the most advanced tumors by means of a nerve block anesthesia. This is a distinct advantage particularly when working in close proximity to the nerve. Some surgeons advocate exposing the facial nerve at once. In our experience we have preferred to avoid any contact with the nerve whenever it was possible to remove the tumor and capsule intact, because working in close proximity to the nerve may lead to the formation of scar tissue and possible paralysis. This was true in one of our cases in which a second operation relieved a paralysis resulting from a previous operation performed elsewhere.

The complete removal of even the normal parotid gland is a difficult operation, but when it is involved by a large malignant growth its successful removal is almost impossible. Conversely, the excision of an early tumor while the capsule is still intact by dividing the gland substance (as shown in Fig. 1) is comparatively simple.

We use the same position as in thyroid surgery, turning the patient's head well to the opposite side. The same preoperative medication, scopolamine gr. 1/150 and pantopon gr. 1/3 is given hypodermically one hour before operation. A second hypodermic of pantopon is given in the operating room. The superficial cervical nerves are then anesthetized by first making a small wheal with 1 per cent novocain just above the clavicle. A long needle is then passed through this wheal and carried subcutaneously along the posterior border of the sternocleidomastoid muscle to the mastoid. The syringe is attached and a small amount aspirated to make sure the needle is not in the vein, and then as the needle is withdrawn the novocain is injected.

Parotid gland tumor in patient fifty-six years of age. Eight years duration. Operable.

The incision should be placed just beneath the angle of the jaw so as to be as little disfiguring as possible, and should extend from the tip of the mastoid downward about 3

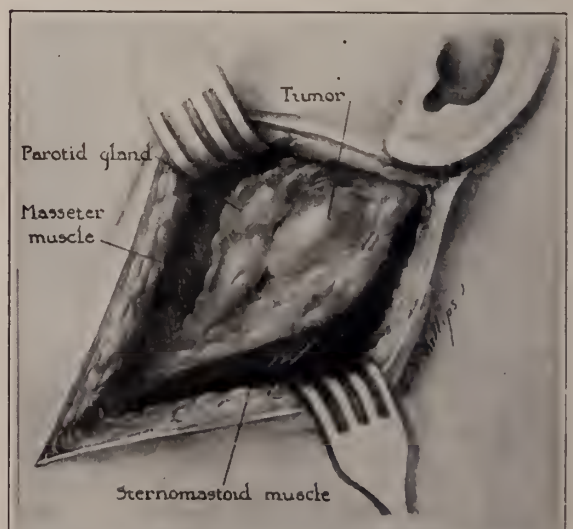

Fig. 1. The parotid gland has been divided and the capsule of the tumor appears.

Shows removal of parotid gland tumor under local anesthetic in girl eighteen years of age.

inches. By sharp dissection the skin and platysma muscles are reflected, the superficial vessels being coagulated by the radio-knife. When the surface of the gland has been well exposed, its substance is gently separated and frequently the capsule of the tumor will be encountered near the surface.

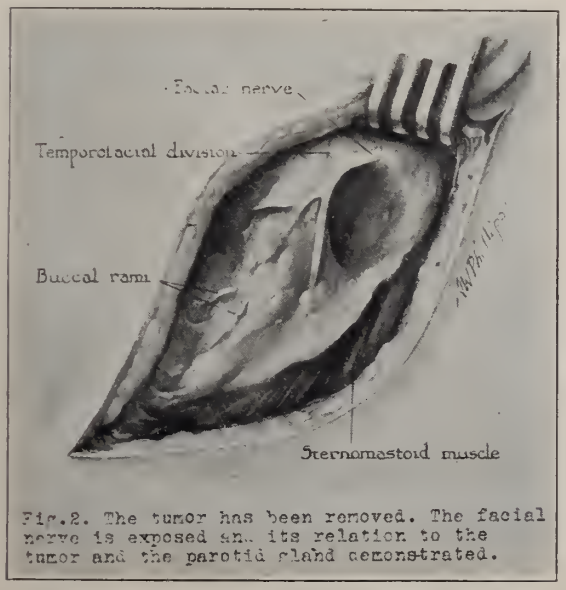

Fig.2. The tumor has been removed. The facial nerve is exposed and its relation to the tumor and the parotid gland demonstrated.

Shows scar same patient, two months after operation.

It is most important then to proceed carefully to dissect out the tumor without rupturing the capsule which is frequently thin and closely adherent to the tissues surrounding it.

Sistrunk says that if the tumor can be removed without rupturing its capsule permanent cure almost always results. In cases in which the capsule is ruptured in removing the tumor, it is best to seize the edges of the capsule gently with forceps and with as little tension as possible, by blunt dissection separate it from the surrounding tissues, making every effort to remove it. The cavity should be washed out with saline solution and then swabbed with Harrington's solution.

If it is necessary to make an incision into the gland substance, as in the removal of a larger or more deeply seated tumor, the incision should be made in the direction of the seventh nerve in order to avoid the danger of cutting across it.

TABULATION

Case	Sex	Age	Duration Symptoms	Treatment	Further Treatment	Pathologic Report	Result
1	F.	55	2 yrs.	Operation 9–23–30. Capsule intact.	Radium	Tumor consists largely of cartilage, capsule not invaded, embryonic epithelial cells. Mixed tumor of parotid.	Well to date.
2	F.	30	1 yr.	Operation 11–13–29 Capsule intact.	Radium	Mixed tumor of parotid. Cartilage and mucoid tissue much epithelial growth. Capsule intact. Prognosis guarded.	Well to date.
3	F.	51	7 yrs.	Operation elsewhere 7 yrs. ago. Operation 10–4–27	Radium	Mixed tumor epithelial elements appear benigh. Tendency toward spindle cell sarcoma. Probable recurrence.	Well to date.
4	F.	52	5 wks.	Operation 12-8-23. Tumor diffuse. Capsule invaded.	X-ray	Now a malignant epithelial tumor of parotid gland. Capsule invaded. Prognosis poor.	Facial nerve sacrificed. Died 7-6-29.
5	M.	37	5 yrs.	Operation 1-4-22. Tumor encapsulated.	X-ray	Mixed tumor of parotid showing cartilage-mucoid tissue and strands of embryonic epithelial cells, capsule not invaded.	?
6	F.	41	5 yrs.	Operation elsewhere 5 yrs. ago. Operation 5-12-30 extensive.	Radium	Extensive recurrence of mixed tumor of parotid gland.	Well—Facial nerve sacrificed.
7	M.	67	6 mos.	Inoperable. Glandular involvement.	Radium	Biopsy report of gland elsewhere—Carcinoma.	Died 8-15-27.
8	M.	53	7 mo.	Excision of tumor and glands radical.	Radium	Mixed tumor of parotid gland malignant with extension to cervical glands (gross report)	? Alive 7-2-27
9	F.	34	6 yrs.	Operation Refused.	None	Large hard mass 2 by 4 cm. involving left parotid gland (gross report)	?
10	M.	59	9 yrs.	Operation delayed for luetic treatment.	None	Hard tumor 3 by 5 cm. involving right parotid gland and probably facial nerve.	Operation elsewhere. Well to date.
11	M.	60	7 mo.	Operation elsewhere 1 yr. ago operation refused.	None	Recurrent parotid gland tumor apparently malignant.	?
12	F.	58	2 yrs.	Operation refused.	None	Mixed tumor rt. parotid 4 by 3 cm.	?
13	F.	7	5 mo.	Inoperable.	None		
14	F.	56	8 yrs.	Operable	None	Mixed tumor Rt. Parotid	Cured to date.
*15	F.	18	4 mo.	Operable	None	*	Cured to date.

* Section: Shows an encapsulated mixed tumor with a variety of connective tissues forming its stroma. The main mass of stroma is fibrillar and quite cellular in some areas, while in others it is cell poor and hyaline. There are also islands of rather embryonic cartilage and areas of myxomatous character. The epithelial aveoli vary from solid aveoli to prickle cells with a tendency to keratinization, to adenomatous aveoli with a lining of a single row of epithelial cells and a hyaline content. The tumor is evidently infected, as two small abscesses are found in the sections.

Fig. IV. Gross specimen, parotid gland tumor.

In spite of every effort to avoid injury to the nerve a temporary paralysis of from one to several weeks may result due no doubt to the edema of the tissues or possibly to pulling and stretching of the nerve. This is particularly so in operating upon recurrent cases where dense adhesions make it difficult to dissect without trauma.

If the facial nerve is involved in a large malignant mass, it is impossible to save it and still remove the growth entirely. In some cases it may be possible by blunt dissection to free and preserve the main divisions (temporofacial and cervicofacial) of the nerve intact. Occasionally it may be possible to suture together the severed nerve ends.

In the radical removal of the gland, one must take into consideration such vital structures as the internal carotid artery, the juglar vein, the pneumogastric, glossopharyngeal, spinal accessory, and hypoglossal nerves. It may be necessary to ligate the external carotid and to ligate temporarily the common carotid arteries. Care must be exercised to avoid injury to the internal jugular vein. Stensons duct must be ligated with chronic gut, and in some cases a fistula may result.

It is essential before attempting any operation on the parotid gland to advise the patient and relatives before operation of the possibility at least of a temporary nerve paralysis. In all extensive cases they should be advised that its sacrifice will probably be required to insure any hope of success.

One advantage of local anesthesia is the fact that by closely watching the face the anesthetist may detect any movements of the muscles and so advise the operator of his close proximity to the nerve.

CONCLUSIONS

1. A study of 15 cases of parotid gland tumors is presented. Operation was performed on 10 of these patients with no operative deaths, and eight of them are still alive with no signs of recurrence.

2. The capsule was ruptured in 4 cases previous to operation and 2 of these patients are dead. This emphasizes the importance of early diagnosis and treatment.

3. The prognosis is excellent in patients who are operated on early and the tumor removed with the capsule intact.

4. The histologic picture is not clear and does not necessarily determine the prognosis. If the capsule is ruptured there is a marked tendency toward local recurrence and metastasis.

5. Surgical removal is not difficult in early cases. If the capsule is ruptured it may be necessary to sacrifice the facial nerve even the external carotid artery.

6. All patients should be advised before operation of the possibility of injury to the facial nerve.

7. Local anesthesia, using the superficial nerve block method, is satisfactory except in advanced cases.

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Embolism and Thrombosis of the Superior and Inferior Mesenteric Vessels; Report of Cases*

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Embolism and thrombosis of the mesenteric vessels belong to the class of acute abdominal conditions. They attract the attention of surgeons as well as general practitioners. Although occlusion of the mesenteric vessels is comparatively rare and difficult to diagnose, it occurs more often than is generally supposed, and the facts concerning it may well be borne in mind when considering a cause for acute abdominal pain.

Reports of embolism and thrombosis of the mesenteric vessels have appeared in the literature since 1843 when Tiedeman first observed the lesion and described a case. Four years later Virchow described the pathologic changes in detail. Many cases have been reported since that time. The reports of Jackson, Porter and Quimby in 1904 thoroughly covered the subject. In 1913 Trotter made a comprehensive review of cases. Dr. Joseph Smith of Wausau in 1919 reviewed the literature and reported three cases. Many men from this country and abroad have added knowledge to the subject until more than 500 cases have been reported most of which pertained to the superior mesenteric vessels. Larson of The Mayo Clinic recently reported necropsy observation in thirty-six cases.

Occlusion of the mesenteric vessels may result from four main causes according to Cokkinis. These are: (1) by trauma and ligature, (2) by external pressure, (3) by embolism and thrombosis, and (4) by inflammatory or degenerative obliteration of their lumen. This paper is concerned only with the most important cause of occlusion; namely, embolism and thrombosis. The condition warrants far more attention than it receives in the text books of today.

Emboli are usually detached portions of blood clots from the walls or valves of the heart. Occasionally, they are masses of bacteria or fat. Coming from the pulmonary veins or the left side of the heart, the embolus passes to the mesenteric arteries by way of the aorta. Suddenly the arterial blood current is cut off. An embolus high in the superior mesenteric artery stops the flow of blood in the entire mesentery, producing extensive thrombosis. When the embolus is low in the artery, thrombosis develops in the occluded area. Although there is collateral anastomosis in the mesenteric vessels, that is, between the branches themselves, life in the tissues is not maintained, since there is an early tendency for thrombosis to spread.

Thrombosis may be arterial or venous. Arterial thrombosis results from: (1) slowing of the blood current as in feeble heart action, pressure or ligation of blood vessels, and (2) alterations in the walls of blood vessels such as from trauma, bacterial invasion (especially in endocarditis and septicemia) and degenerative lesions of blood vessels including arteriosclerosis and atheroma. Venous thrombosis results from trauma, surgical or accidental, phlebitis, enteritis, colitis, diverticulitis, appendicitis, salpingitis, hepatic cirrhosis, or neoplasms. Thrombosis is said to be primary when confined to the original site of formation and secondary when descending in type, as from the liver or portal tube.

The usual results of thrombosis on the tissues are hemorrhagic infarction generally followed by gangrene, and loss of function. Anemic gangrene is a possibility. The mesentery becomes edematous and congested; circulation ceases. There is extravasation of blood into the tissues. The bowel becomes gangrenous when thrombosis occurs in the terminal arcades or vasa recta. It then becomes dark red or black and moist with bloody fluid. Peristalsis is diminished or absent. In infective cases peritonitis develops. Whenever any vessel becomes occluded the outcome depends to some ex-

* Presented before 90th Anniversary Meeting, State Medical Society of Wisconsin, Madison, Sept., 1931.

tent on whether collateral circulation with other vessels may be established. This brings up the question of the difference between the inferior and superior mesenteric vessels.

In considering occlusion of the superior mesenteric vessels it is well to remember that the superior mesenteric artery is large in caliber, arising just below the celiac axis and running almost parallel to the aorta for several centimeters. It draws a large volume of blood, supplying all of the small intestine with the exception of the upper part of the duodenum, also the cecum, the appendix, the ascending colon and about half of the transverse colon. It is a likely trap for emboli, and has poor collateral circulation to protect itself. In the duodenum the inferior pancreaticoduodenal of the superior mesenteric artery anastomoses with the superior pancreaticoduodenal of the hepatic artery. While in the transverse colon the middle colic branch of the superior mesenteric artery inosculates with the left colic branch of the inferior mesenteric artery. Thus this long section of small and large bowel is protected by collateral circulation with other vessels only at either end.

The inferior mesenteric vessels are rarely thrombosed. Few cases are on record. The inferior mesenteric artery arises from the anterior surface of the abdominal aorta three to four cm. above the bifurcation of that vessel into the two common iliac vessels. It is less than half the size of the superior mesenteric artery and leaves the aorta at a wider angle, making it less likely to receive emboli. The following branches are given off: the left colic to the left portion of the transverse and descending colon, the sigmoid branches to the sigmoid colon, and the superior hemorrhoidal to pelvic colon and upper rectum. This latter vessel anastomoses with the inferior hemorrhoidal of the internal pudic. Above, the left colic branch anastomoses with the right colic branch of the superior mesenteric. Thus, collateral circulation of the inferior mesenteric is abundant with other vessels.

HISTORY

In taking the history one should be on the outlook for one or more of the following factors: infective or degenerative heart disease, arteriosclerosis, nephritis, appendicitis, hepatic cirrhosis, trauma of the abdomen, enteritis, or history of recent abdominal operations. The usual age limits are twenty to sixty-five years although Frank reports three cases of eight, ten and twelve years.

SYMPTOMS

In general, symptoms are those of acute intestinal obstruction. As given by many authors, they are as follows: (1) abdominal pain, severe in nearly all cases, sudden when brought on by embolism; pain may be general or localized; (2) nausea and vomiting; vomitus commonly blood stained; (3) fever as peritonitis sets in; (4) leukocytosis; (5) diarrhoea appearing early and with blood stained stools in half of the cases; (6) obstipation developing later as bowels become paralyzed; and (7) collapse. General physical examination reveals tenderness and rigidity, many times localized over the right side of the abdomen or in the umbilical region. Abdominal distention is more pronounced in the later stages. Signs of free fluid in the peritoneal cavity may be noted.

DIFFERENTIAL DIAGNOSIS

In the differential diagnosis one should consider appendicitis of the perforative type, ruptured peptic ulcer, volvulus, cancer of the colon and intussusception.

PROGNOSIS

The prognosis is very bad; the mortality rate is 90 to 95 per cent. This can and should be improved.

TREATMENT

Surgical intervention should be undertaken within the first few hours to prevent the spread of thrombosis and to prevent peritonitis. Spinal anesthesia would now be the anesthetic of choice. If the intestinal lesion is not too extensive and if the patient's condition permits, resection with end-to-end anastomosis is preferable. The incision must extend into healthy tissue. Ileostomy or colostomy may be indicated. Delay is the great obstacle to success.

I shall report three cases, two involving the superior mesenteric vessels and one very uncommon case of thrombosis of the inferior mesenteric vessels.

REPORT OF CASES

Case 1. A woman aged forty years referred by Dr. C. F. Peterson entered the Whitehall Community Hospital September 30, 1926, because of severe abdominal pain which had existed since the previous day. Nausea and vomiting developed with shortness of breath. The temperature was subnormal and the pulse weak and thready.

The abdomen was distended, with marked general tenderness. The patient was in shock and too weak for laparotomy. Leukocytes numbered 15,000. The urine was heavy with albumen, and there was blood in the stools.

Ileostomy was resorted to October 8, merely to relieve pain from distension. Death occurred eight hours later.

Necropsy disclosed infarction of a large portion of ileum, and thrombosis of superior mesenteric artery; the wall of the bowel was black and a large amount of bloody fluid was found in the peritoneal cavity.

Comment: It is significant that the past history in this case records valvular heart disease, leading one to suspect the possibility of embolism.

Case 2. A woman aged forty years entered the Whitehall Community Hospital March 19, 1927. Three days before admission the patient had had a sudden attack of abdominal pain, which gradually became more severe, and nausea and vomiting appeared. On the afternoon of admission the abdominal pain was excruciating. The knees were drawn up. The patient threw herself about in bed. The pain seemed out of proportion to physical condition. Picture was different from ruptured viscus.

On examination the abdomen was only slightly distended; there was moderate general tenderness, and shifting dullness in the flanks. The temperature was normal, the pulse was 120 and very weak. Leukocytes numbered 20,200.

Laparotomy disclosed the ascending and transverse colon to be distended and dark. Hemorrhagic infarction of mesentery, thrombosis of the arteries, and bloody fluid in the peritoneal cavity were found. Resection was not possible. Death occurred the following day.

Case 3. A man aged forty-one years was admitted to the Whitehall Community Hospital December 11, 1923. Slight nagging pains had been present over the lower abdomen for several months. Difficulty was experienced in getting bowels to move. Severe cramp-like pains in lower part of the abdomen for last ten days had localized over the left lower quadrant; they were accompanied by chills and fever.

Abdomen was distended, and there was rigidity in lower half. Leukocytosis was present. The temperature was 100.6°F.; the pulse was 96. December 12 a median line incision was made. Free fluid was found in the peritoneal cavity with low grade peritonitis; segment of mesentery of the sigmoid 12 by 5 by 4 cm. showed hemorrhagic infarction. The inferior mesenteric vessels were thrombosed. Peristalsis of the affected sigmoid segment apparently was absent, although there was no infarction of the wall of the bowel. The thrombosed mass was freed from newly formed adhesions and the peritoneum was drained. Abundant collateral circulation of the inferior mesenteric vessels gave assurance of maintaining life of the bowel until drainage of peritoneal cavity restored strength of patient and gave resection better hope of success. May 17, 1924, I operated again. The infarcted mesentery had undergone necrosis and abscess formation; the sigmoid colon was but slightly inflamed. I resected 17.5 cm. of the sigmoid and a v-shaped portion of the mesentery, making an end-to-end anastomosis. The patient made an uneventful recovery, with the exception of the development of a slight fecal fistula, which later healed.

Comment: This was a case of thrombosis of the inferior mesenteric vessels of which only a few are reported in the literature.

CONCLUSIONS

1. When considering the cause of acute abdominal pain embolism and thrombosis of the mesenteric vessels should be borne in mind.

2. The lesion occurs more often than is generally supposed; three cases have been observed by the writer in the past eight years.

3. Embolism and thrombosis of the mesenteric vessels may be expected in association with infective or degenerative heart disease, arteriosclerosis, appendicitis, hepatic cirrhosis, enteritis, colitis, trauma, and following recent abdominal operation.

4. The symptoms resemble those of acute intestinal obstruction. More specifically the diagnostic features are: (1) acute abdominal pain, (2) nausea and vomiting, often with blood in the vomitus, (3) early diarrhoea followed by obstipation, (4) melena, and (5) shock.

5. The treatment calls for prompt and courageous surgical intervention with wide resection of the involved bowel and mesentery. The intestine is best brought together with end-to-end anastomosis. Early operation prevents spread of thrombosis and peritonitis.

6. Three cases are reported; two involving

the superior mesenteric vessels, and one unusual case affecting the inferior mesenteric vessels with recovery.

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THE JOURNAL CLINIC

Rat-Bite Fever—Report of a Case

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Our purpose in this paper is to present a short discussion of rat-bite fever and to report a case which occurred in a laboratory worker at the University of Wisconsin.

Rat-bite fever has long been known in Japan. Early accounts of the disease were given by Wilson and Watson in 1840, but it remained for Katsura (1892) to give the first clear-cut description of the condition. In 1902 Miyake published an account of the disease under the name of "Rattenbiss-Krankheit" and called attention to the Japanese name of "Sodoku" ("so"-rat and "doku"-poison). Since this time the American literature has presented many cases sporadically observed in this country.

Rat-bite fever, or sodoku, is an acute infectious disease, usually, but not always, contracted from the bite of a rat and characterized by a variable incubation period, by paroxysms of fever, by local inflammatory reaction about the bite wound with contiguous lymphatic glandular enlargement and by a bluish-red macular exanthem.

The disease follows the bite of a rat, weasle, ferret, cat, or squirrel. In 1916 Futaki discovered a spirochete present in the local lesion. He termed this organism "spirocheta morsus muris" and since 1916 this spirochete has been proven to be the etiologic agent.

As to the actual pathology present, little can be said for reports have varied. Some cases have shown no distinctive pathology while others reveal subacute myocarditis with cellular infiltration, subacute hepatitis and nephritis, renal and splenic infarction, catarrhal changes of the mucosa of the stomach, intestines and urinary bladder, and hyperemic changes of the lungs, pancreas, adrenals, meninges and the brain.

The symptoms and signs usually follow from one to three weeks after the animal's bite; however, incubation periods as short as three days and as long as five months have been reported. The onset is sudden and is ushered in by rigor, a rapid rise in temperature, headache, increase in pulse and respiration, and pains in the joints and muscles. The cardinal symptoms and signs which consist of the primary lesion, the fever, the rash, and muscular pains soon become prominent. It has been observed that the shorter the incubation period, the more severe is the disease.

Primary lesion: After the bite, the wound heals, but with the onset of the febrile symptoms the tissue about the scar becomes

swollen, edematous, and is accompanied at times by a regional lymphangitis and adenitis. Some cases go on to ulceration. Such ulceration resembles an extra-genital chancre as suggested by the clean surface, indurated edges and serous discharge. There is a recrudescence of pain and local inflammation with each succeeding fever. The wound later heals leaving a bluish or purplish tint. There are, however, some cases reported in which the primary lesion is absent.

Fever: The pyrexia lasts two to three days, reaches a temperature of 101° to 104° F and then falls suddenly with an afebrile period of from three to seven days occurring before the sudden rise of another pyrexial period. If the disease is untreated, it would probably subside gradually. Some cases are reported lasting as long as four, eight, and even twenty years. During the pyrexia remission all symptoms disappear.

Rash: The rash is one of the most characteristic signs. It is present only during the periods of fever and subsides with the decrease in temperature. It may occur on any part of the body, neck, and even on the mucous membranes. The rash is a peculiar purplish shade, contrasting fairly sharply with the surrounding tissues. Such a rash is macul-papular, painless, free from itch and will disappear when considerable pressure is exerted. At times, ecchymoses may occur, or in other cases vesicles have been observed.

Muscular pains: These are the most common symptoms and are most marked in the calf of the leg and in the arms. They precede and accompany the rises of temperature. After the patient becomes entirely free, he may continue to have periodic muscle pains. Other symptoms are quite frequent. At the termination of the infection an urticarial rash may occur. This is a hopeful sign. Symptoms of gastro-enteritis occur and are due to catarrhal inflammation of the mucosa. Diarrhea is rare. The heart and lungs are rarely involved except for a rare myocarditis or a purulent pleurisy. There is no liver enlargement or jaundice. There may be giddiness, tinnitus, and headaches, but rarely delerium or coma. Anaesthetic patches may occur in the lower extremity and at other points on the body. Photophobia and conjunctivitis have been noted.

CLINICAL VARIETIES

Four clinical varieties have been described.

1. Afebrile type with only subjective symptoms which are mild in character.
2. Type showing continuous temperature, which may be severe with marked nervous symptoms and prove rapidly fatal, or mild and abortive with slight constitutional symptoms.
3. The intermittent type, showing recurring pyrexial attacks, the inflammatory reaction and characteristic bluish-red eruption.
4. Miscellaneous types—cases not classified above and which may show the local symptoms predominating, the incubation period shorter or absent, or other changes from the usual type.

The blood reveals a progressive anemia with a leucocytosis and slight eosinophilia at the height of the fever and a tendency to lymphocytosis during the remission. The Wassermann is usually positive.

The urine often reveals albumin, rarely contains casts, and has a positive test for urobilinogen.

A definite diagnosis is made by injecting mice or guinea pigs intraperitonially with blood taken from the patient at the height of the fever, and recovering the organisms from the peripheral blood of these animals after an incubation period of from five to fifteen days.

The treatment is by the intravenous use of arsenical or antimony derivatives.

CASE REPORT

The following is the summary of a case seen in the Student Health Department at the University of Wisconsin: E. K., a white female 28 years old, entered the Student Infirmary April 21, 1932, with the chief complaint of an infected right thumb. She stated that two days previous while working in the laboratory she was bitten on her thumb by an apparently healthy rat used for experimental purposes. Since she had had numerous rat bites by

laboratory animals, she thought nothing of this bite until April 21 when she noticed a swelling of the thumb and tenderness around the site of the bite. Examination at this time revealed two small red areas on the palmar surface of the thumb where the rat had bitten the patient. The entire thumb was swollen and hyperemic. A dark red streak extended from the thumb along the medial surface of the forearm to the axilla. The patient's temperature was 100° F, pulse 102, white blood count 7200 with 85% neutrophiles. With hot compresses to the thumb and elevation of the arm, the lymphangitis quickly subsided and the temperature went to normal.

On the afternoon of April 22 the patient's temperature started to rise, so that by April 23 it had reached 103° F. Associated with this rise of temperature there was the appearance of bluish-red, discrete maculae first on the abdomen, then on the forearms, hands and wrists, legs and face. There was a severe headache, nausea and vomiting, chills, and pains in the muscles of the legs. The original rat bite was practically healed. Blood cultures and smears showed nothing. The blood Wassermann was negative. The white blood count was 25,600 with 96% neutrophiles. The urine showed no abnormalities. The temperature ran a hectic course until April 27 when it reached normal. With the fall in temperature, the white blood count reached 8,850 with 66% neutrophiles. The rash practically disappeared. The muscle pains were much less severe, the nausea and vomiting subsided, and the patient felt very much better in every way.

Three days later (April 30) the patient's temperature went up to 102°, the blood count went to 15,650 W. B. C. with 85% neutrophiles and the macular rash reappeared. This recurrence of symptoms lasted for 3 days. It was felt that the patient had rat-bite fever and she was given 25 mgm. arsenical 158 intravenously. Subjectively, the patient was improved after this but her temperature continued to rise in the afternoons, the muscle pains persisted, and though the maculae disappeared, a few petechiae persisted around the elbow joints and hands and some small vesicles appeared on the palmar surface of the hands and the plantar surfaces of the feet. By May 7 the Wassermann was 4 plus.

The patient continued with a slight rise of the temperature and blood count associated with the appearance of a few new vesicles every 3rd to 4th day until May 21. From that time on she was well enough to be up out of bed much of the time, but every 3rd to 4th day her leg muscles would ache, the white blood count would go from 16,000 to 21,150, and the temperature would go to 99°–100° to remain there for only a few hours. The Wassermann had become negative. The attacks gradually became milder and farther apart until June 11, 1932, when the patient was discharged from the Infirmary. Since then she occasionally has the muscle pains in her legs, but she has been able to resume her normal activities. The vesicles and petechiae on the hands and feet have entirely disappeared. The blood Wassermann remains negative.

Repeated samples of the patient's blood were taken during the febrile periods and inoculated into mice and rats but the spirochaeta was never recovered from these animals.

This patient was treated by bed rest, analgesics for the muscle pains, and local hot applications to the original rat bite. In addition she received six intravenous injections of arsenical 158 and two of neoarsphenamine.

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Secretaries of state medical societies will hold their annual conference at the headquarters of the American Medical Association in Chicago in November. Problems common to the state societies will be discussed at this meeting.

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EDITORIALS

A NEW ENDOCRINE SYNDROME

TO NO one man in the world does the medical profession owe more in its knowledge of the pituitary body than to Dr. Harvey Cushing. For years he and his associates have been intensively studying the hypophysis, and have been publishing the progress of their work.

In March, 1932, Dr. Cushing made a signal contribution relating to what was heretofore known as a polyglandular syndrome and recently (July) he has supplemented his original report with evidence which seems to leave no doubt but that he has separated from the obscurities of a polyglandular syndrome the cause of a very definite condition. Might we be so bold as to suggest that this pituitary disorder be named "Cushing's disease"?

"The disorder is characterized by a rapidly acquired plethoric adiposity affecting the face, neck and trunk, the extremities being spared. It is associated in women with hypertrichosis and amenorrhea. Other characteristic features are vascular hypertension, purplish striae distensae of the abdomen, and acrocyanosis with cutis marmorata of the extremities. It is often accompanied by hyperglycemia, occasionally by polycythemia, and a peculiar softening of the bones of the skeleton has been commonly found at autopsy. In its extreme forms, the malady has more often been encountered in young adults, and the average duration of life in the fatal cases has been something over five years".

It had been suspected for years that such a syndrome was of endocrine origin and most authors blamed the adrenal cortex, recognizing however that there was polyglandular disturbance.

One fact which undoubtedly has retarded the recognition of the cause of this syndrome is the great difficulty frequently experienced in obtaining permission in an autopsy to open the head. Further, as Cushing observes, the pituitary gland was often removed, a section cut and the gland said to be normal. Only serial sections of the anterior portion of the gland will reveal at times the small tumor which is composed of basophil cells and which is considered to be the cause, a hyperpituitary state.

As is well known, there are three main types of cells in the anterior pituitary body, (a) a cell without granules, a neutrophil, (b) a cell with acidophilic granules, (c) a cell with basophilic granules. The first has no known function although it may have. The second is the source of the growth promoting function, the third of the sex stimulating function. Tumors of the first cells are known as chromophobe, tumors of the second and third as chromophil tumors. States of

overproduction as well as deficiency occur. Further, innumerable degrees of overproduction and deficiency are recognizable.

Cushing has brilliantly analyzed fifteen cases of the syndrome described above, finding some in the literature with several of his own. In six out of eleven cases examined post mortem basophil adenoma was found. In view of the fact that in at least one case where the gland was said at first to be normal and serial sections later revealed a small adenoma, the negative reports are not convincing when serial sections were not cut.

There is no doubt but that the disorder is fairly common. The writer remembers that he has seen just such cases as Cushing so vividly portrays. The condition is not confined to women, five out of fifteen cases occurred in men. In the male the deficiency of sex stimulating hormone and the acquisition of secondary sex characters of the opposite sex are not as striking as in the female.

Now that this syndrome has been lifted out of the waste basket of the polyglandular syndromes it is hoped that some means may be found to control the basophil hypersecretion. The pituitary acidophilism (acromegaly) can often be much benefited by x-ray therapy. In one of Cushing's cases this therapy seemed to be of decided help.

As time has gone on, endocrinology is being rescued from fields of imagination and speculation and is being placed on a firm physiological and pathological basis. We look forward with renewed hope to the time when more of the obscure syndromes will have the brilliant light of sound investigation shed upon them. L. M. W.

The Basophil Adenomas of the Pituitary Body and Their Clinical Manifestations (Pituitary Basophilism), Bull. Johns Hopkins Hosp., 50: 137–195 (March) 1932.

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STUDENT HEALTH

RECENT statistics of the incidence of tuberculosis among medical students would indicate that there was something wrong somewhere.

A survey indicates that tuberculosis is much commoner among juniors and seniors than among freshmen and sophomores in medical schools. In one school there was one case in the first two years and thirteen cases in the last two years. And further evidence seems to point to the fact that the danger of contracting active tuberculosis increases with the length of time in school.

Medical students as a class are as select a group of risks as one could find. Physicians as a group are relatively long lived; the average age at death being sixty-three years, just ten years older than in the population as a whole which is fifty-three years. It would then seem that tuberculosis should be much less frequent among medical students than among a cross section of the population, but this does not seem to be the case.

What the explanation of this increased incidence of tuberculosis is we do not know, but it is a situation which requires some further study. Going back over our own experience in medical school and hospital it makes one pause to wonder how any considerable number of men could stand up under the program and not develop illness.

Conditions today with the curricula piling up and the demands of faculties and hospitals increasing are not lighter than they were formerly, but if anything the demand upon a young man's strength is greater.

It may be that the old adage fits: Shoemakers children are bootless, and medical students without medical care.

Universities as a whole are more and more alert to their responsibilities toward the health of the students. The professional schools perhaps have shared less in this task than undergraduate institutions.

We know that many students who are helping put themselves through school are inadequately housed and fed, and over worked. Is there a chance here to put our house in order and take the lead in establishing ideal living and working conditions for as valuable a group of young men as exist anywhere?

A survey of health conditions, hours of work, sleep, recreation and living conditions among medical students might be a valuable, practical step in the teaching of preventive medicine and hygiene, and might disclose some reasons for the high incidence of tuberculosis in students. H. P. G.

Reginald Henry Jackson, M. D.

President, State Medical Society of Wisconsin, 1933

Dr. Reginald Henry Jackson was born in De Pere, Wisconsin, in 1876. His family moved to Madison shortly thereafter and Dr. Jackson received his common school education in the schools of Madison. He pursued a combined classical and pre-medical course at the University of Wisconsin. In 1899 he graduated in medicine at Columbia University College of Physicians and Surgeons, New York City, and then served as house surgeon at the Presbyterian Hospital in New York City from 1900 to 1902.

At the close of 1902, Dr. Jackson returned to Madison to take up practice with his father and he has been in continuous practice in that city since returning from New York. Specializing in surgery, Dr. Jackson is a fellow of the American College of Surgeons, a member of the Western Surgical Association, a member of the Southern Surgical Association, and has long been a member of the Dane County Medical Society, the State Medical Society of Wisconsin, and a fellow of the American Medical Association.

THE PRESIDENT'S PAGE

Reginald H. Jackson

ADDRESS BEFORE THE 1932 HOUSE OF DELEGATES

Mr. Speaker, Members of the House of Delegates:

YOUR deliberate action a year ago, in electing me incoming President of the Society, deserves, on my part, an expression of gratitude for the signal honor thus conferred.

While at the time I was duly impressed with the honor, I am at present overwhelmed with the sense of responsibility. During the past year I have been made aware through attendance at meetings of the Council, the Committee on Public Policy, and as Chairman of a special committee of the constantly increasing perplexities and problems which confront our profession. From various hints given me by my predecessors in office, I now anticipate not only a year of honorable distinction but one filled also with arduous work and worry.

However, this is as it should be and, if I am not mistaken, will be the lot of my successors in office for many years to come. It must be apparent to all of us that if we, as a profession, are to maintain our position and hope to better it, such end can be attained only through eternal vigilance, thoughtful foresight and united action.

The day of our individualism has gone. We must develop a stronger sense of unity not only for ourselves but for those who are to follow us. The strength of the wolf lies in the pack and it is time we realized that many of the forces which assail us are unwittingly grouping themselves together in this fashion.

I am convinced that there is inherent in the membership of our Society all the resources of wisdom, courage and ability essential to solve the problems before us.

The constructive recommendations which Dr. Fiedler has offered meet with my approval. I shall make only one suggestion at this time.

Many of our problems and perplexities are associated with the activities society resorts to in its humanitarian efforts to relieve physical suffering. There is at times on the part of society and its agents a fundamental lack of understanding of the motives which actuate us in our attitude towards some of these activities. Doubtless, at times, our profession also fails to sympathetically comprehend the problems and motives of some of the agencies engaged in public preventive medicine and other fields.

I should like to see established in this state a far closer liaison than exists at present between the private practitioner of medicine and all other organizations, public or philanthropic, which have to do with any phase of health.

There already exist in this state all the physical requirements and personnel essential to care for the health problems of the population in a satisfactory way. To insure harmonious cooperation there should be an annual meeting of minds of those interested in the various phases—a voluntary Bureau of Correlated Health Activities—composed of the permanent secretaries, the active and past presidents, and the councilors of all the existing present agencies, a forum at which many perplexing questions could be presented and intelligently solved to the mutual advantage of society and organized medicine. Unless organized medicine occupies a central position and serves as a socially sympathetic guiding influence in molding the pattern of things medical, the medical profession of this state will inevitably become steadily more subservient to lay supervision under political domination.

To put into effect this suggestion will place an additional burden upon the shoulders of our secretary. Based upon my personal observation during the past year, I should like to pay a sincere tribute to his work and personality. If I had been asked two years ago what I thought of him, I would probably have replied, "Oh, George is a good fellow," and let it go at that, thus betraying my own delinquency in failing to keep in touch with the many problems which are always on his desk pressing for solution. Today, I say he is an exceptionally capable man, in the right place. I feel that our Society is singularly fortunate in having a man of his training and ability constantly occupying the key position in our organization.

The majority of us are too busy as practitioners to note in the ever changing current of passing events those things which concern us as physicians until they are accomplished facts. I believe that in the future there will arise many situations where foreknowledge on our part of proposed activities by others will provide opportunity for mutual consideration and compromise adjustment, and that a Bureau of Correlated Health Activities with George Crownhart as one of our liaison officers is worth our consideration and effort.

While acting as your President, I am your servant and shall aim to serve the best interests of those you represent.

I am fully conscious of the personal lack of many of those qualities so essential to adequately fill the position to which you elected me. I trust you will individually feel free to extend to me through personal interview or correspondence the guiding influence of your knowledge and matured thought on all problems pertaining to our beloved profession. Of your loyalty, I have no doubt. I thank you.

A REQUEST FROM THE PRESIDENT

The President of the State Medical Society of Wisconsin is, after all, but trying to voice those problems common to the great group of the membership and to suggest, where he may, some means looking towards ultimate solutions. So it is, concerned with *your* problems, your President will welcome your personal communications throughout his year in office. It will be indeed a very real service if you, the membership, will feel free to address him with your suggestions and your constructive criticisms.

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SOCIETY PROCEEDINGS

BROWN-KEWAUNEE

The Brown-Kewaunee County Medical Society held its first fall meeting on September 6th at Stangelville. This proved to a very interesting meeting and was thoroughly enjoyed by all members present. W.E.M.

DANE

Members of the Dane County Medical Society met for dinner and golf at the Stoughton Country Club at Lake Kegonsa on Friday, September 2nd. A short business meeting was held in the evening.

FOND DU LAC

A meeting of the Fond du Lac County Medical Society was held at Hotel Retlaw at six-thirty o'clock on August 30th at Fond du Lac. Dr. D. T. Quigley, physician in charge of the Radium hospital at Omaha, Nebraska, addressed the members on "The Use of Radium in the Treatment of Malignancy."

Dr. Quigley was also a speaker before a meeting of the Fond du Lac Kiwanis Club during his stay there.

GREEN LAKE-WAUSHARA-ADAMS

The Green Lake-Waushara-Adams County Medical Society and the Woman's Auxiliary met in the Grand View hotel at Ripon on August 25th for their regular meeting and banquet. Mr. Lester J. Burr, attorney, was the speaker of the evening, his subject being "Deadbeat Accounts in the Profession."

MILWAUKEE

The first meeting of The Medical Society of Milwaukee County of the 1932-1933 season will be held on October 14th, at the Pfister Hotel.

Hospital interns of Milwaukee County have been invited to submit case reports before October 1st, for which the following prizes will be awarded:

1st prize	$15.00
2nd prize	$10.00

The program committee will select those deserving of prizes and the winners will present their reports at this meeting.

The following scientific program will be presented:

"Direct Signs of Duodenal Ulcers," by M. E. Gabor, M. D.

"Tachycardia," by Louis M. Warfield, M. D.

OUTAGAMIE

Dr. Otho A. Fiedler, Sheboygan, addressed the members of the Outagamie County Medical Society at a meeting of the society at the Riverview Country Club at Appleton on September 1st. Dr. Fiedler spoke on the care of the indigent sick in Wisconsin.

A golf tournament preceded the dinner and meeting.

ELEVENTH COUNCILOR DISTRICT

The annual meeting of the Eleventh Councilor District was held at Castle Gardens Resort, Lake Nemakagon, near Cable, Wisconsin.

Following the dinner at twelve-thirty, Dr. J. M. Dodd of Ashland read the minutes of the charter meeting of the local county society in 1892. Other speakers on the program and their subjects were:

Dr. A. M. Snell of the Mayo Clinic,—"Liver Function and Its Relation to Disease."

Dr. W. S. Middleton, Madison,—"Diet in The Treatment of Kidney Disease."

Dr. R. D. Mussey of the Mayo Clinic,—"Menarche, Menstruation and Menopause."

Dr. R. C. Buerki, Madison,—"The Wisconsin Genral Hospital."

A business meeting followed the scientific program.

MILWAUKEE ACADEMY OF MEDICINE

A meeting of the Milwaukee Academy of Medicine was held on September 20th.

Dr. Julius Bauer, professor of internal medicine, University of Vienna, was the speaker of the evening, his subject being "Newer Aspects of Endocrinology."

On September 20th, 21st, and 23rd, Dr. Bauer gave a course in endocrinology. Two sessions were held daily.

WISCONSIN UROLOGICAL SOCIETY

A meeting of the Wisconsin Urological Society was held on September 30th and October 1st in the Wisconsin General Hospital, Madison. The program consisted of the following papers:

Friday, beginning 9:30 A. M.

"Postoperative Oxygen Therapy," by Dr. E. A. Rovenstine, Madison.

"Respiratory and Circulatory Changes During Spinal Anesthesia" by Dr. M. H. Seevers.

"Pharmacological Basis for Use of Hypnotics in Clinical Medicine" by Dr. A. L. Tatum, Madison.

"Choice of Anesthetic, Drug and Dosage," by Dr. Ralph M. Waters, Madison.

"The Treatment of Syphilis of the Central Nervous System" by Dr. W. J. Bleckwenn.

Friday, beginning 2:30 P. M.

"A Study of Chronic Infection in the Male Urethra and Genital Tract, with a Presentation of a New Urethroscope for Diagnosis and Treatment," by Dr. Damon A. Brown, Madison.

"A Case of Anuria" by Dr. Charles Lynch, Milwaukee.

"Case Report" by Dr. H. M. Stang, Eau Claire.

"Interesting Tumor of the Kidney" by Dr. George H. Ewell, Madison.

"Etiological Factors in Pyelitis of Pregnancy" by Dr. Harold L. Morris, Detroit.

"The Problem of Preoperative Drainage in Prostatic Obstruction" by Dr. Hugh Cabot, Rochester.

A banquet at the Loraine Hotel at seven o'clock concluded the day's program.

On Saturday at nine-thirty A. M., the following program was given:

"The Difficulties and Dangers of Transurethral Resection" by Dr. James C. Sargent and Dr. C. R. Marquardt of Milwaukee.

"Resectoscope Demonstrations" by Dr. Ira R. Sisk, Madison.

THE WOMAN'S AUXILIARY

Mrs. Fred A. Nause, Jr., Sheboygan, *President*
Mrs. Eben J. Carey, Milwaukee, *President-elect*
Mrs. Walter Ford, Sheboygan, *Secretary*
Mrs. Raymond G. Arveson, Frederic, *Treasurer*
Mrs. Walter Jackson Freeman, Philadelphia, *National President*
Mrs. James Blake, Minnesota, *President-elect*
Mrs. James C. Sargent, Milwaukee, *Editor*

National Convention, Milwaukee, June 1933

The annual meeting of the Woman's Auxiliary to the State Medical Society of Wisconsin was held in Milwaukee, September 13th to 16th. Upwards of two hundred doctors' wives were registered and both the business and the social meetings were very well attended. One hundred and twenty-seven ladies were served at the opening breakfast at the Colony Inn and one hundred and fifty-eight attended the luncheon and business meeting on the following day at the College Woman's Club. Fifteen members availed themselves of the golf privileges provided by Mrs. John Blair at the North Hills Country Club, and about one hundred guests attended the delightful tea given by Mrs. Rock Sleyster in her beautiful home and gardens.

In their addresses to us Dr. William A. Evans, Chicago; Dr. Otho Fiedler, Sheboygan, retiring president of the State Society and Dr. Louis Jermain, Milwaukee, made us feel that there is work of real worth to be accomplished by an active auxiliary.

The executive board of the state auxiliary elected the following nominating committee: Mrs. T. J. Gunther, Sheboygan; Mrs. Morris Ross, Brodhead; Mrs. R. G. Arveson, Frederic; Mrs. Joseph Lettenberger, Milwaukee and Mrs. James C. Sargent, Milwaukee. The slate which they presented at the business meeting on Thursday was unanimously accepted as follows: Mrs. E. J. Carey, Milwaukee, President-elect; Mrs. W. A. Ford, Sheboygan, Secretary and Mrs. R. G. Arveson, Frederic, Treasurer. Mrs. Fred A. Nause, Jr., of Sheboygan, president-elect of last year assumed her duties as president at this time.

As Mrs. Henry Gramling, Milwaukee, retires as President of the state auxiliary, it is the wish of the entire auxiliary to express to her our appreciation of her able leadership and our recognition of her unusual ability in directing the course of such an organization. To her and her state officers is due the credit of this most successful year.

The auxiliary is appreciative also of the fact that much of the success of this annual meeting was due to the splendid help given us by the State Medical Society. Their interest in the well-being of the auxiliary was definitely manifested by their thoughtful cooperation in the activities of the entire auxiliary convention. Among the many kindnesses which they performed for us was the presentation by Mr. Crownhart of a gavel to the state auxiliary.

For the happy entertainment of auxiliary members we are greatly indebted to Mrs. Louis Warfield, Milwaukee County Convention Chairman, and her able committees who foresaw so clearly the desires and pleasures of all those attending the convention.

The state auxiliary was especially honored by having as its guest Mrs. Walter Jackson Freeman, president of the National Auxiliary. No one who heard any of her short, peppy talks, could but be imbued with the great interest and enthusiasm for the work of the Auxiliary. Besides adding much of interest to the meetings of the state auxiliary, Mrs. Freeman laid the foundation for much of the plan for the National Auxiliary meeting to be held in Milwaukee in June, 1933. She appointed Mrs. Rock Sleyster as National Convention Chairman and had many conferences with her and the new state officers giving inestimable help in her suggestions for the June meeting.

* * *

Your new state publicity chairman would appreciate having the county publicity chairman send any news items of interest to her by the fifteenth of each month so that she may compile them for the State Journal. Please mail such notices to Mrs. James C. Sargent, 2924 N. Stowell Avenue, Milwaukee.

REGISTRATION AT MILWAUKEE

Mrs. J. J. Adamkiewicz ----------Milwaukee
Mrs. R. G. Arveson ----------Frederic
Mrs. M. J. Bach ----------Milwaukee

Mrs. J. E. Ballard ---------- Wauwatosa
Mrs. E. L. Baum ---------- Milwaukee
Mrs. C. H. Baumgart ---------- Milwaukee
Mrs. C. J. Becker ---------- Milwaukee
Mrs. Claude Beebe ---------- Milwaukee
Mrs. Lewis Belknap ---------- Wauwatosa
Mrs. H. P. Benn ---------- Stevens Point
Mrs. R. D. Bergen ---------- Milwaukee
Mrs. Louis A. Bernhard ---------- Milwaukee
Mrs. M. D. Bird ---------- Marinette
Mrs. F. E. Blackburn ---------- Cassville
Mrs. John Blair ---------- Milwaukee
Mrs. A. L. Bork ---------- West Allis
Mrs. C. D. Boyd ---------- Kaukauna
Mrs. F. E. Brinckerhoff ---------- Beloit
Mrs. A. W. Bryan ---------- Madison
Mrs. A. J. Caffrey ---------- Milwaukee
Mrs. Stephen Cahana ---------- Milwaukee
Mrs. P. L. Callan ---------- Milwaukee
Mrs. H. J. Cannon ---------- Milwaukee
Mrs. E. J. Carey ---------- Milwaukee
Mrs. S. L. Casper ---------- Medford
Mrs. B. P. Churchill ---------- Milwaukee
Mrs. F. T. Clark ---------- Waupun
Mrs. W. C. Comee ---------- Green Bay
Mrs. Gregory Connell ---------- Oshkosh
Mrs. George Crownhart ---------- Madison
Mrs. Max Cutler ---------- Chicago, Ill.
Mrs. R. J. Dalton ---------- Milwaukee
Mrs. I. Z. Davidoff ---------- Milwaukee
Miss Vivian Davies ---------- Racine
Mrs. D. L. Dawson ---------- Rice Lake
Mrs. A. V. de Neveu ---------- Milwaukee
Mrs. Paul Doege ---------- Marshfield
Mrs. W. W. Duke ---------- Kansas City, Mo.
Mrs. Paul Eisele ---------- Ripon
Mrs. J. J. Eisenberg ---------- Milwaukee
Mrs. P. J. Eisenberg ---------- Milwaukee
Mrs. D. V. Elconin ---------- Milwaukee
Mrs. Paul Epperson ---------- Milwaukee
Mrs. H. J. Farrell ---------- Milwaukee
Mrs. Otho Fiedler ---------- Sheboygan
Mrs. Robert Friedrich ---------- Milwaukee
Mrs. W. J. Freeman ---------- Philadelphia, Pa.
Mrs. W. J. Fleming ---------- West Allis
Mrs. U. E. Gebhard ---------- Milwaukee
Mrs. E. H. Gramling ---------- Milwaukee
Mrs. Henry Gramling ---------- Milwaukee
Mrs. R. J. Gray ---------- Brooklyn
Mrs. Arthur Grob ---------- Milwaukee
Mrs. Otto Gunther ---------- Sheboygan
Mrs. Theo. Gunther ---------- Sheboygan
Mrs. J. E. Habbe ---------- Milwaukee
Mrs. James H. Hackett ---------- Milwaukee
Mrs. C. F. Hardy ---------- Milwaukee
Mrs. T. L. Harrington ---------- Wauwatosa
Mrs. H. P. Haushalter ---------- Milwaukee
Mrs. Harry M. Hawkins ---------- Milwaukee
Mrs. A. H. Heidner ---------- West Bend
Mrs. F. G. Heidner ---------- Milwaukee
Mrs. George Hoffman ---------- West Allis
Mrs. G. I. Hogue ---------- Milwaukee
Mrs. W. W. Hume ---------- Milwaukee
Mrs. R. K. Irvine ---------- Manawa
Mrs. Edward Jackson ---------- Milwaukee
Mrs. F. R. Janney ---------- Wauwatosa
Mrs. Hubert Jermain ---------- Milwaukee
Mrs. William Jermain ---------- Milwaukee
Mrs. W. J. Jones ---------- La Crosse
Mrs. W. A. Joseph ---------- Milwaukee
Mrs. H. E. Kasten ---------- Beloit
Mrs. E. E. Kidder ---------- Stevens Point
Mrs. Arthur Kovacs ---------- Milwaukee
Mrs. F. A. Kretlow ---------- Milwaukee
Mrs. W. C. Lambert ---------- Chicago, Ill.
Mrs. W. C. Leifert ---------- Milwaukee
Mrs. Joseph Lettenberger ---------- Milwaukee
Mrs. Benjamin Lieberman ---------- Milwaukee
Mrs. O. R. Lillie ---------- Milwaukee
Mrs. W. N. Linn ---------- Oshkosh
Mrs. R. H. Ludden ---------- Viroqua
Mrs. J. D. Madison ---------- Milwaukee
Mrs. P. J. Majerus ---------- Ft. Atkinson
Mrs. Frank Margoles ---------- Milwaukee
Mrs. L. Margoles ---------- Wheeler
Mrs. S. M. Markson ---------- Milwaukee
Mrs. W. A. Martins ---------- Milwaukee
Mrs. J. V. May ---------- Marinette
Mrs. G. F. Mitchell ---------- Milwaukee
Mrs. F. D. Murphy ---------- Milwaukee
Mrs. N. E. McBeath ---------- Milwaukee
Mrs. F. X. McCormick ---------- Milwaukee
Mrs. J. J. McGovern ---------- Milwaukee
Mrs. R. E. McDonald ---------- Milwaukee
Mrs. W. J. McKillip ---------- Milwaukee
Mrs. Fred A. Nause, Jr. ---------- Sheboygan
Mrs. C. D. Neidhold ---------- Appleton
Mrs. George W. Neilson ---------- Milwaukee
Mrs. T. O. Nuzum ---------- Janesville
Mrs. Orvil O'Neal ---------- Ripon
Mrs. C. W. Osgood ---------- Evansville
Mrs. M. M. Perlson ---------- Milwaukee
Mrs. P. H. Perlson ---------- Milwaukee
Mrs. E. C. Pfeifer ---------- Racine
Mrs. A. G. Pfeiler ---------- Sheboygan Falls
Mrs. F. W. Pope ---------- Racine
Mrs. R. P. Potter ---------- Marshfield
Mrs. C. C. Reinke ---------- Milwaukee
Mrs. E. L. Reynolds ---------- Columbus
Mrs. H. M. Ripley ---------- Kenosha
Mrs. Morris Ross ---------- Brodhead
Mrs. Glenway Rothenmaier ---------- Elkhart Lake
Mrs. James C. Sargent ---------- Milwaukee
Mrs. U. A. Schlueter ---------- Milwaukee
Mrs. E. R. Schmidt ---------- Madison
Mrs. E. J. Schneller ---------- Racine
Mrs. Raymond Schowalter ---------- Milwaukee
Mrs. Gilbert E. Seaman ---------- Milwaukee
Mrs. C. U. Senn ---------- Medford
Mrs. E. L. Sevringhaus ---------- Madison
Mrs. M. W. Sherwood ---------- Milwaukee
Mrs. S. J. Silbar ---------- Milwaukee
Mrs. Rock Sleyster ---------- Wauwatosa
Mrs. L. D. Smith ---------- Milwaukee
Mrs. T. J. Snodgrass ---------- Janesville
Mrs. Willard Sonnenburg ---------- Sheboygan
Mrs. Simon Spilberg ---------- Milwaukee
Mrs. M. M. Spitz ---------- Milwaukee
Mrs. R. P. Sproule ---------- Milwaukee
Mrs. Charles H. Stoddard ---------- Milwaukee
Mrs. J. H. Sure ---------- Milwaukee
Mrs. W. L. Stranberg ---------- Milwaukee
Mrs. Victor Taugher ---------- Milwaukee
Mrs. R. E. Teschan ---------- Milwaukee
Mrs. E. L. Tharinger ---------- Milwaukee
Mrs. D. P. Thill ---------- Milwaukee
Mrs. I. F. Thompson ---------- Racine
Mrs. S. Trinz ---------- Chicago, Ill.
Mrs. Millard Tufts ---------- Milwaukee
Mrs. L. H. Wagner ---------- Milwaukee
Mrs. H. G. Walters ---------- Racine
Mrs. L. M. Warfield ---------- Milwaukee
Mrs. H. E. Webb ---------- Milwaukee
Mrs. R. Weiss ---------- Milwaukee
Mrs. J. B. Wilets ---------- Milwaukee
Mrs. Theodore Wiprud ---------- Milwaukee
Mrs. Will Young ---------- Ft. Atkinson
Mrs. R. L. Zaegel ---------- Sheboygan
Mrs. Alfred Zlatnik ---------- Two Rivers

PROCEEDINGS IN DECEMBER

Minutes of the business meetings of the Auxiliary will be published in the December issue of the Journal.

NEWS ITEMS AND PERSONALS

Jean Ann Loughnan, 14, daughter of Dr. and Mrs. A. J. Loughnan of Oconomowoc died on July 10th of acute nephritis at Summit Hospital, Oconomowoc.

—△—

Dr. J. A. Mudroch of Columbus was recently elected a director of the Farmers & Merchants Union Bank at Columbus.

—△—

Dr. M. H. Wirig, for the last three years associated with the Dean Clinic, Madison, opened his own offices in the Wisconsin Power and Light Building at Madison in September.

—△—

Drs. J. J. and H. R. Sharpe of Fond du Lac moved into new offices the first of September. Need for additional space and a complete clinic necessitated the change.

—△—

Dr. David C. Atwood, who finished internship at Wisconsin General Hospital, Madison, has opened an office at 23 South Pinckney street, Madison, for the general practice of medicine and surgery.

—△—

Chiropractors in Wisconsin will ask the 1933 legislature for the right to treat the sick in the public institutions of Wisconsin according to a story in the Milwaukee Journal in announcing the annual sessions of the Wisconsin Association of Chiropractors in Milwaukee on October 10 and 11.

—△—

Dr. J. M. Johnson of Ripon has received appointment as resident physician for the Chicago & Northwestern Railroad.

—△—

Dr. David Wigod, formerly of Milwaukee, has opened an office for the practice of medicine and surgery in the village of Warrens in Monroe County.

—△—

Dr. and Mrs. Horace K. Tenney, Jr., Madison, spent a two weeks' vacation in northern Michigan.

—△—

Dr. Harmon H. Hull, who has been assisting Dr. W. H. Housley of Neillsville, has opened offices at 935 Michigan avenue, North Fond du Lac. Dr. Hull is a graduate of the University of Wisconsin Medical School in 1931.

—△—

There were 83 accidental drownings in Wisconsin during the first six months of 1932, a reduction of eight from the figures of a year ago, the State Board of Health announced recently.

—△—

An estate of $4,000 was left in a will by a Madison resident to the Madison General Hospital to be used to pay for the care of charity cases in that hospital.

—△—

Drs. G. B. McKnight of Fond du Lac and H. A. Keenan of Stoughton were named members of the physician-trustees committee of the Wisconsin Sanatorium Trustees Association.

—△—

Dr. Helen Davis, Madison, has returned from Europe, where she spent the summer. She attended a meeting of the British Medical Association in London and visited continental clinics.

—△—

Dr. Charles F. Ulrich has moved his offices from the Kenosha Clinic to 323 Epstein building, Kenosha.

—△—

Cancer claimed an average of 292 victims monthly during the first seven months of 1932, the State Board of Health announced. The number represents a decrease of 1.5 per cent deaths from the monthly average for the same period in 1931.

—△—

The next written examination of the American Board of Obstetrics and Gynecology will be held on Saturday, October 22nd, in nineteen different cities in the United States and Canada. For application blanks and other information, address Dr. Paul Titus, secretary, 1015 Highland Building, Pittsburgh, Pa.

—△—

Dr. Orville E. Damp, who served internships at Mercy and St. Mary's hospitals at Oshkosh and at Milwaukee Children's hospital, Milwaukee, has opened an office for the practice of medicine at Stockbridge.

—△—

Dr. C. A. Harper, state health officer, addressed a meeting of the Wisconsin Supervising Teachers held in West Allis in September.

—△—

Dr. C. J. Ryan of Adams has disposed of his practice to Dr. C. A. Dodson, formerly of Palmyra. Dr. Ryan has moved to Loyal, Wisconsin, where he has opened an office.

—△—

Physicians who have recently been licensed to practice in Wisconsin and who have opened offices include the following:

Dr. Lawrence G. Patterson, a graduate of Ohio Medical University in 1931, is practicing at Scandinavia.

Dr. Albon W. Overgard, a graduate of University of Wisconsin Medical School in 1931, has moved into the Citizens Bank building at Stanley.

Dr. Arthur C. Stehr, a graduate of University of Wisconsin Medical School in 1931, has opened an office at 503 State Street, Madison.

Dr. Emmett A. Meili, a graduate of University of Wisconsin Medical School in 1931, is practicing at Cochrane, Wisconsin.

—△—

Dr. H. H. Milbee, Marshfield, was named president of St. Joseph's Hospital staff, to succeed the late Dr. K. W. Doege. Dr. Harry Vedder was chosen as vice-president and Dr. W. G. Sexton, secretary. Members of the staff selected a resolutions committee composed of Dr. L. A. Copps, Dr. W. G. Sexton, Dr. William Hipke and Sister Mary Margaret.

—△—

MILWAUKEE

Dr. Paul M. Currer and family returned to Milwaukee on September the sixth from Pelican Lake where they enjoyed a ten-day vacation.

—△—

Dr. A. W. Gray is convalescing at his home, following a tonsilectomy at Columbia Hospital on August 23rd.

—△—

Reverend Herman L. Fritschel, superintendent of Milwaukee Hospital, was honored on August 19th at an informal dinner, given in appreciation of his many years of service. The banquet was attended by about forty-six friends and a number of out-of-town medical associates.

The dinner was followed by chapel services which were attended by over three hundred.

—△—

Dr. and Mrs. Henry O. McMahon returned recently from a pleasure trip to Columbus, Ohio, where they were the guests of Mr. and Mrs. William C. McMahon.

—△—

Dr. and Mrs. Arthur T. Holbrook sailed from New York on September the sixth for Europe. After a brief sojourn they expect to embark on a Mediterranean cruise. After visiting the Holy Land and Egypt they expect to sail for home, arriving in New York the latter part of October.

—△—

Mrs. Bertha Bergner, wife of Dr. O. L. Bergner, died at her home, 3301 N. Fourth Street, on August 28th, at the age of forty-three years. She was a life-long resident of Milwaukee.

Besides her husband Mrs. Bergner is survived by two sons, Wyman and Kenneth; her mother, Mrs. Emma Clayus; four sisters, and two brothers.

—△—

Dr. and Mrs. Frank E. Darling, Jr., and son, Frank E., left Milwaukee about the middle of September to take up their residence in Philadelphia, where Dr. Darling will attend the Postgraduate School of the University of Pennsylvania, to study obstetrics and gynecology.

—△—

Dr. J. E. Rueth presented a paper,—"Physiotherapy, An Essential Specialty in Medicine,"—before the American Congress of Physical Therapy, in New York City on September 7th.

Dr. Eben J. Carey, professor of anatomy at Marquette University, has announced that arrangements for foreign medical science exhibits at the Century of Progress Exposition to be held in Chicago in 1933 are completed. Exhibits will be entered from Italy, England, France, Germany, Belgium, Holland, Denmark, Austria, and Czecho-Slovakia.

Dr. Carey twice has been cited for honors by the American Medical Association for his scientific anatomical exhibits. He was appointed Director of the Medical Exhibit for the Fair in June, 1931.

—△—

Dr. Roland Alfred Jefferson of Denver, Colorado, arrived in Milwaukee early in September to become medical director of the Milwaukee Mental Hygiene Council at 110 E. Wisconsin Avenue.

Dr. Jefferson received his medical training at Dartmouth College and at the College of Medicine, University of Nebraska. From 1928 to 1932 he served as assistant physician at the Colorado Psychopathic Hospital. He was lecturer in psychiatry at the University of Colorado College of Medicine and at the University of Denver College of Law.

Dr. Jefferson will give a series of lectures for social welfare workers.

—△—

The following health talks, sponsored by the State Board of Health and delivered by Mr. Theodore Wiprud, executive secretary of The Medical Society of Milwaukee County, will be broadcast over the Milwaukee Journal Station, WTMJ, during this month: October 14th—How Are You?; October 21st—The Old Medicine Chest; October 28th—Electrical Hazards in the Home.

—△—

Dr. and Mrs. Henry B. Hitz spent the summer at Pine Lake, Wisconsin. They expect to return to Milwaukee in the early fall.

—△—

Dr. and Mrs. Frederick Stratton left on September the first for Belchertown, Massachusetts, to attend the wedding of their nephew, Mr. John Stratton, and Miss Charlotte Fuller. On their way to Belchertown Dr. and Mrs. Stratton stopped in New York to meet Dr. and Mrs. Frank Wilson, who came from Paris to attend the wedding.

—△—

Dr. and Mrs. J. Gurney Taylor returned to Milwaukee on September the 8th from a motor trip through New York and Pennsylvania.

—△—

Dr. F. F. Dollert gave an illustrated talk to the agents of the Travelers Protective Association at their meeting on September the 8th.

—△—

Dr. and Mrs. Gilbert E. Seaman have returned to Milwaukee after spending the summer at their country home on Oconomowoc Lake.

—△—

Dr. S. E. Kohn, who spent several months abroad, studying in Berlin, Dusseldorf, Breslau, Vienna, and

Paris, returned to Milwaukee on September 1st to resume his practice in pediatrics.

—△—

The Women's Evening Clinic, established to provide medical and dental care for women and girls who are unable to pay for such services, and who cannot attend day clinics, opened its second season on September 5th, at the Mount Sinai Hospital Dispensary, 934 N. Twelfth Street.

The medical staff is made up of the following physicians: Drs. Eleanore Cushing-Lippitt, Director of the Clinic, Gail Moxon, Rose Kriz-Hettwer, Elsa B. Edelman, Frances Johnson, Nina Tomkiewicz, Ida Schell, Elisabeth Seiler, and Florence MacInnis.

—△—

Dr. Lawrence G. Sykes, son of Dr. H. D. Sykes, formerly medical director of the Connecticut General Life Insurance Company, was recently appointed medical director of the Life Extension Institute. This position formerly was held by the late Dr. Eugene Lyman Fisk.

After his graduation from the University of Illinois College of Medicine, Dr. Sykes practiced medicine in Milwaukee for several years. He was Secretary of the Milwaukee Academy of Medicine from 1920 to 1924. At the present time Dr. Sykes is First vice-president of the Association of Life Insurance Medical Directors.

—△—

Six lectures on "Nutrition and Its Relation to a Program of Health," concerning diets for certain common metabolic diseases such as diabetes, anemia, tuberculosis, etc., will be given by the Milwaukee-Downer College beginning October 13th, and ending November 17th.

These lectures are to be given by Professor Susan F. West, director of the Department of Home Economics, and Miss M. Ruth Wallace, instructor in Home Economics, on Thursday evenings from 7:30 to 8:30 P. M.

—△—

Dr. LeGrand M. Cox expects to sever his connections with the Hagenbeck-Wallace Circus for this year when the season closes on October first. Dr. Cox found his work with the medical department of the circus, which covered ten states during its 1932 season, very interesting.

—△—

Dr. Edward N. Schoolman, Chicago psychiatrist, began his series of twelve lectures on psychological subjects on Tuesday evening, September 21st, at the Jewish Center, at which time his subject was "Psychology and the Art of Living." Lectures are to be given each Tuesday evening through December sixth.

—△—

The cornerstone for the new $450,000 nurses' home at the Milwaukee County General Hospital was laid on September the fifteenth.

—△—

Matson Holbrook, son of Dr. and Mrs. Arthur T. Holbrook, who are at present enjoying a Mediterranean cruise, left on September the 18th for Cambridge, Massachusetts, where he is a student at Harvard University.

—△—

Drs. A. L. Curtin, D. W. Curtin, S. H. Wetzler, and M. W. Shutkin on September first announced the opening of their new offices in suite 905, Mariner Tower, at 606 W. Wisconsin Avenue.

—△—

Dr. Philip J. Eisenberg is now located at 606 W. Wisconsin Avenue, having moved from his former location at 808 N. Third Street.

—△—

On September 23rd, The Medical Society of Milwaukee County, together with the Physicians' Service Bureau, moved to their new offices in the Bankers Building, 208 E. Wisconsin Avenue.

—△—

Dr. Arthur W. Hankwitz, son of Dr. and Mrs. Paul Hankwitz, is in Vienna where he is studying at the University of Vienna.

—△—

Dr. Julius Bauer of Vienna, Austria, who attended the annual meeting of the State Medical Society was the house guest of Dr. and Mrs. Louis M. Warfield during his stay in Milwaukee.

—△—

Announcement has been made of the engagement of Miss Jane Alberta Daniels, daughter of Dr. and Mrs. L. J. Daniels, to Mr. Frederick C. Beck of Milwaukee. The wedding will take place early in October.

—△—

Dr. and Mrs. John B. Hitz and daughter left Milwaukee on September fifteenth for New York from where they sailed on the sixteenth for Europe. Dr. Hitz expects to take a postgraduate medical course in Vienna.

—△—

Miss Winifred Eleanor Roby, daughter of Dr. and Mrs. Harlow S. Roby, was married to Mr. Ralph Goff Abbott, of San Antonio, Texas, on September third in the Timothy Stone Chapel of the Fourth Presbyterian Church, Chicago.

—△—

The Speakers' Bureau, sponsored by the educational committee of The Medical Society of Milwaukee County, was represented during the month of September by Drs. Millard Tufts and D. W. Roberts.

On September 22nd, Dr. Tufts addressed the members of the Woman's Community Club on "Are You Overweight."

Dr. D. W. Roberts was the guest speaker at the meeting of the Garfield Lodge of the Knights of Pythias at its meeting on September 26th. His subject was "Keeping Mentally Fit."

BIRTHS

A son to Dr. and Mrs. John Huston, Milwaukee, on August 21st.

A son to Dr. and Mrs. B. I. Bender, Milwaukee, on August 25th.

A son to Dr. and Mrs. Herbert L. Herschensohn, Milwaukee, September 10th.

ENGAGEMENTS

Announcement has been made of the engagement of Miss Jane Alberta Daniels, daughter of Dr. and Mrs. L. J. Daniels.

MARRIAGES

Dr. Walter A. Brussock, Milwaukee to Miss Cheryl Miller in Milwaukee on September first.

Dr. Clarence M. Schuldt, Platteville, to Miss Zelma Itten of New Glarus at New Glarus on September 2nd.

Dr. Dean Echols, son of Dr. and Mrs. Chester M. Echols, Milwaukee, to Miss Frances Foerster, daughter of Dr. and Mrs. Otto H. Foerster, also of Milwaukee, on September 10th.

After a wedding trip, Dr. and Mrs. Echols will be at home in Ann Arbor, where Dr. Echols is a resident physician at the University hospital.

DEATHS

Dr. F. J. Antoine, Prairie du Chien, died on September 15th following a week's illness.

Dr. Antoine was born November 1, 1876, at Lake Church, Wisconsin, and received his medical education at University of Illinois College of Medicine, Chicago in 1905. Following graduation, he served internship at St. Francis hospital, La Crosse, and then came to Prairie du Chien to practice, remaining there for the past twenty-six years. He had long been prominent in civic affairs having served as health officer for twenty-one years, mayor of the city from 1930 to 1932, and was a member of the Knights of Columbus and the Catholic Knights of Wisconsin.

Dr. Antoine was a member of Crawford County Medical Society, the State Medical Society of Wisconsin, and was a fellow of the American Medical Association.

He is survived by his widow, two sons and one daughter.

Dr. Ray C. Blankinship, Madison, died suddenly of coronary thrombosis on August 23rd at the home of his brother-in-law in Huntington, West Virginia, as he was concluding an automobile trip with his daughter, Betty.

Born in Brookmeal, Virginia, in the year 1890, Dr. Blankinship was a graduate of the Medical College of Virginia, Richmond, in 1914. He served internship in the King County Hospital, New York, and returned to Virginia to practice medicine. At the outbreak of the World War, he enlisted as a medical officer and was stationed at Houston, Texas. Immediately after the war, he came to Stoughton, Wisconsin, where he practiced a year before coming to Madison to join the teaching staff as instructor in clinical medicine at the University of Wisconsin Medical School. In 1922 he was awarded an assistant professorship, and in 1925 he was named an associate professor.

Dr. Blankinship was a member of the Dane County Medical Society, the State Medical Society of Wisconsin, and was a fellow of the American Medical Association.

He is survived by his widow and one daughter.

Dr. Adolf Pannkoke, Milwaukee, died on August 31st at his home after an illness of several months.

Dr. Pannkoke was born in the year 1853 and was a graduate of the University of Gottingen, Germany, in 1879. He had been a resident of Milwaukee since he came there from Germany when he was a young man.

He is survived by two daughters and one son.

Dr. Andrew A. Baumstark, Milwaukee, who for many years practiced medicine in Milwaukee prior to his retirement a number of years ago, died at his home, 912 N. 19th Street, Milwaukee on September 11th.

» » » CORRESPONDENCE « « «

"OF VERY GREAT BENEFIT"

Eyota, Minn., Sept. 20, 1932.

State Medical Society of Wisconsin,
Radio Station WHA, University of Wisconsin,
Madison, Wisconsin.
Miss Ruth Buellesbach, Assistant:

Imagine my surprise this afternoon to get from the radio a voice, rather familiar, and to hear you in your splendid discussion of the childhood diseases. I was particularly interested in it from the standpoint of vaccination and the prevention by early recognition and watchfulness on the part of the parents. It seems very hard to impress most mothers with the value of prevention and I wish that every parent in this community might have had the opportunity of listening to you this afternoon.

You may not receive a very great response from the physicians and general public, but I am sure that your talks are of very great benefit to a large number of people and I for one appreciate the work that you are doing.

Respectfully yours,

W. Howard Parker, M. D. (Wis. '30)

"FRATERNAL GREETINGS"

MICHIGAN STATE MEDICAL SOCIETY

Grand Rapids, Mich., September 17, 1932.

Mr. J. G. Crownhart, Secretary,
State Medical Society of Wisconsin,
Madison, Wisconsin.
Dear Mr. Crownhart:

Your telegram, conveying greetings of the State Medical Society of Wisconsin to the Michigan State Medical Society in Annual Meeting assembled in Kalamazoo, was received after our House of Delegates had adjourned and our General Sessions were oveer. I did read the telegram to the Council and imparted it to a goodly number of our members present. I was instructed by the Council to convey to you and to your officers and members our appreciation of this thoughtfulness and to assure you that it was their hope that the Wisconsin society had experienced as profitable a session as had our State organization.

Our meeting was the best we have had in several years and was attended by the largest number of members since our 1927 meeting. I trust the same was your experience because the inspiration has come to us that our fellow members are sincerely interested in organizational work and the advancement of scientific medicine, in order that we may, as citizens, better discharge our professional duties and acquit ourselves commendably of our public responsibility.

Again expressing in behalf of our membership our appreciation for your fraternal greetings, I am

Yours very sincerely,
F. C. WARNSHUIS,
Secretary.

Over Nine Hundred Registered At Ninety-first Anniversary Meeting; Dr. Stanley J. Seeger, Milwaukee, Chosen President-elect.

With over nine hundred twenty-five physicians registered during the three-day session, the State Medical Society of Wisconsin set a new record for attendance at its annual meeting at the ninety-first anniversary session in Milwaukee, September 13th–16th. The entire fourth and fifth floors of the Schroeder were given over to the meeting rooms for the one hundred twenty presentations made during the three days.

Dr. Stanley J. Seeger, Milwaukee, was named as President-elect of the Society; Dr. Ralph M. Carter of Green Bay, Speaker of the House of Delegates; Dr. Walter G. Sexton of Marshfield, Vice-speaker, and a thirteenth councilor district was created to consist of Oneida–Vilas, Langlade, Price–Taylor, and Forest county societies. These societies were all in the old eleventh district which, in the future, will consist of the Douglas, and Ashland–Bayfield–Iron county societies. The division was essential because of the large territory included in the older districting.

Dr. I. E. Schiek of Rhinelander was named councilor for the new thirteenth district and Dr. G. R. Duer of Marinette was elected to succeed Dr. T. J. Redelings, resigned, in the eighth district. Dr. H. M. Stang, Eau Claire, of the tenth district; Dr. Joseph F. Smith, Wausau, of the ninth district, and Dr. Spencer D. Beebe, Sparta, of the seventh district were re-elected as councilors. Drs. J. Gurney Taylor, Milwaukee, and W. E. Bannen of La Crosse were re-elected delegates to the American Medical Association and Drs. T. W. Nuzum, Janesville, and F. Gregory Connell, Oshkosh, were re-elected as alternate delegates.

In accordance with action taken in 1931, the 1933 session of the Society will be held in conjunction with the meeting of the American Medical Association in Milwaukee in June, next. The State Society meeting will be confined to sessions of the House of Delegates.

Despite the very large attendance and extensive program with its section meetings, every session ran within five minutes of schedule throughout the entire three days and over five hundred were present for the last address on Friday afternoon presented by Dr. Julius Bauer of Vienna.

A feature of the meeting was the round table luncheon conferences held on Thursday noon which, although expanded to accommodate two hundred forty members in twelve separate discussional groups, was still found to be insufficient to accommodate all who desired to attend these popular meetings. Over three hundred members were in attendance at the hospital clinics which opened the scientific meeting from eight to ten on the first day.

HOUSE OF DELEGATES

The House of Delegates was literally flooded by the major questions presented at

this session. Meetings were held on both Tuesday and Wednesday evenings, and the final session was held on Thursday morning, September 15th. Important actions of the House are summarized following:

1. **Adopted unanimously the report of the special committee to study admissions to the State of Wisconsin General Hospital, and instructed the committee to proceed towards the accomplishments of the ends outlined in this report.**
2. **Adopted the progress report of the special committee on the distribution of medical services in Wisconsin.**
3. **Referred to the Council, after referendum vote in the county societies, the question of whether the Society should favor legislation or conferences with insurance carriers as a means of securing for the injured under the Workmen's Compensation Act, free choice of physicians among all willing and capable.**
4. **Adopted all committee reports as published in the August issue of the Wisconsin Medical Journal with but two minor changes.**
5. **Voted unanimously to retain $15.00 dues that the Society might carry into effect the progressive program outlined for 1933.**
6. **Confirmed the following appointments of President-elect Jackson:**

Committee on Scientific Work: Dr. Arnold S. Jackson, Madison, for the term ending September, 1935, to succeed Dr. W. S. Middleton, Madison.

Committee on Public Policy: Dr. S. E. Gavin, Fond du Lac, for the term ending September, 1935, to succeed Dr. S. M. B. Smith, Wausau.

Editorial Board: Dr. George H. Ewell, Madison, for the term ending September, 1935, to succeed Dr. Joseph F. Smith, Wausau.

Committee on Medical Defense: Dr. R. M. Carter, Green Bay, for the term ending September, 1935, to succeed Dr. W. C. Becker, Watertown.

Committee on Medical Education and Hospitals: Dr. F. D. Murphy, Milwaukee, for the term ending September, 1935, to succeed himself.

PROCEEDINGS OF THE HOUSE

Because of the large amount of business transacted at this session of the House of Delegates, it is not possible for the stenotype reporter to complete her records in time to have this material appear in the November issue. The verbatim record of the House transactions will appear as a supplement to the December issue of the Journal.

Committee on Medical Economics: Dr. W. G. Riopelle, Beaver Dam, for the term ending September, 1935, to succeed Dr. T. D. Smith, Neenah.

Committee on Health and Public Instruction: Dr. W. G. Sexton, Marshfield, for the term ending September, 1935, to succeed Dr. C. M. Gleason, Manitowoc.

Advisory Committee on Medical Extension: Dr. E. F. Schneiders, Madison, for the term ending September, 1935, to succeed Dr. M. D. Bird, Marinette.

Committee on Cancer: Dr. D. L. Dawson, Rice Lake, tenth district, to succeed Dr. H. M. Stang, Eau Claire. Dr. R. L. MacCornack, Whitehall, seventh district, to succeed Dr. Herman Wolf, La Crosse. Dr. Cyril G. Richards, Kenosha, second district, to succeed Dr. F. W. Pope, Racine. Dr. Gideon Benson, Richland Center, fourth district, to succeed Dr. E. H. Spiegelberg, Boscobel, and Dr. Geo. E. Moore, Antigo, to represent the new thirteenth district.

All were appointed for the term ending September, 1935.

WISCONSIN GENERAL HOSPITAL

Conferences with the Regents of the University of Wisconsin to work out possible changes in policies at the State of Wisconsin General Hospital which it is thought will relieve the institution of its present overload and give a more adequate specialized care for the public patients, were authorized by the House of Delegates. The delegates adopted the report of the special committee which has been studying this subject matter over a long period of time.

The substance of the recommendations which the Society will make to the Regents are:

1. Limiting the care of public patients to those actually in need of specialized service which cannot well be obtained

in local institutions at a similar cost to the counties.

2. An improvement in the form of record of the admission of the part-pay patient to prevent any abuse of the facilities that the state offers, by patients who are not deserving of these facilities.
3. Care of private patients by faculty members in local hospitals other than the Wisconsin General Hospital that the floor space now devoted to private cases may be given over to the indigent and semi-indigent.

It was pointed out that the public patients who are sent to Madison as joint state and county charges increased in number from 2,816 in the year ending July 1, 1930, to 4,584 in the year ending July 1, 1932. It is suggested by the Society that this rate of increase may not continue without necessitating large additions and that inasmuch as the State Hospital was primarily erected to render a specialized service, it seems probable that more local care for the patient not in need of specialized service should be instituted at this time. The Committee suggests that Wisconsin hospitals generally are only filled to slightly more than 50% of capacity and that in such instances where local care is entirely adequate, it will preserve the local hospital and reduce the local costs of hospitalization to the pay patients of the communities in the state. The Committee indicated that the cost of the state and county cases in the last fiscal year was in excess of $800,000 and believes that this may be cut materially by instituting such regulations as will confine the acceptance of cases in Madison to those who are in real need of facilities which cannot readily be obtained locally.

It was reported that the second recommendation for a somewhat greater formalization of records as relates to the semi-indigent patients appeared to meet with the general approval of hospital authorities.

With reference to the private-pay patients, the House of Delegates was informed that 14% of all the admittances to the State Hospital during the calendar year of 1931 were 1,110 private patients and that the fees accruing to essentially full time staff members were approximately 60% of and in addition to the amount paid in salaries. The House concurred in the recommendation of the Committee that faculty members who were doing but little private work should preferably be retained on a full time basis and that those staff members who were to be continued on a part time basis should be confined to the treatment of private patients outside the hospital that the substantial amount of floor space at the hospital now devoted to private rooms for private cases might be given over to the care of the indigent and semi-indigent.

It was indicated that conferences have already been held with the officers of the institution looking towards such changes as outlined above as will, in the opinion of all concerned, promote the best interests for the adequate care of the indigent sick in this state.

RESOLUTIONS RECEIVED

One amendment to the Constitution was adopted at this session of the House to provide that members of the Council, while enjoying all privileges of the House of Delegates, are not to be considered as voting members of the House. An amendment to the By-Laws extends the time for payment of medical defense dues from February first to March thirty-first to bring the time limit in conformity with that set for the payment of all dues.

Dr. H. P. Bowen of Watertown presented a resolution to the Constitution, which will lie on the table for one year, to the effect that Councilors shall be elected in the councilor district meetings rather than by the House of Delegates after nomination from delegates in the district.

A resolution by Drs. C. F. N. Schram and P. A. Fox of Beloit referring to progress in the distribution of medical services was referred to the special committee on that subject.

A resolution by Dr. George F. Adams of Kenosha presented by the Committee on Resolutions asked the Committee on Public Policy to study the New York plan for the State Board of Health and make recommendations for changes in the Wisconsin law. This resolution was adopted.

The House received several resolutions from Dr. John J. McGovern, Milwaukee, a past president of the Society, referring all to the Committee on Public Policy with the exception of one suggesting a revision of the councilor districts on the basis of membership, and one suggesting legislation to curb religious types of healing, which resolutions were placed on the table.

When the House convened for its first session on Tuesday evening, September 13th, Speaker Stanley J. Seeger, made the following appointments to reference committees of the House who reported their recommendations to the Wednesday evening session:

Credentials: Dr. Henry Gramling, Milwaukee, Chairman. Dr. I. E. Schiek, Rhinelander; Dr. L. V. Littig, Madison.

Reports of Officers: Dr. T. J. O'Leary, Superior, Chairman; Dr. Edith McCann, Milwaukee; Dr. A. J. Gates, Tigerton.

Reports of Standing Committees: Dr. Gunnar Gundersen, La Crosse, Chairman; Dr. C. F. Peterson, Independence; Dr. A. E. McMahon, Glenwood City.

Resolutions: Dr. R. M. Carter, Green Bay, Chairman; Dr. R. G. Arveson, Frederic; Dr. R. W. Jones, Wausau; Dr. D. E. W. Wenstrand, Milwaukee; Dr. George F. Adams, Kenosha.

ANNUAL DINNER

Close to three hundred members were in attendance at the annual dinner held in the evening of the second day of the meeting. Following presentation of the officers for the coming year and presentation of the Council Award, the address of the evening was made by Dr. Richard E. Scammon, Dean of the Medical Sciences at the University of Minnesota, who spoke on "The Foundation and Early History of St. Bartholomew's—the First Hospital in London." The evening was concluded with dancing and cards.

COUNCIL AWARD TO DR. GLASIER

"The success that has crowned so many of the public spirited projects of our State Medical Society of Wisconsin since its organization in 1841, and the strong position that we occupy today, has been the result of the work of no one man, nor of the efforts of a few,"

Mina B. Glasier, M. D.

declared Dr. Arthur W. Rogers, Chairman of the Council, speaking for the Society at the annual dinner on Thursday evening, in presenting the award to Dr. Mina B. Glasier of Bloomington, for fifty years a practitioner and over thirty years the Secretary of the Grant County Medical Society.

"From as far back in the history of our Society as I can recall," continued Dr. Rogers, "I am impressed by the responsiveness of members and officers alike to their individual duties and needs of their State Society.

"It is true, of course, that certain men, by virtue of the responsibilities vested in them by their fellow members, have had larger opportunities for service. Thus a secretary of a county medical society, a councilor or a president may, by his untiring work, leave behind him outstanding accomplishments. We, in Wisconsin, have had large numbers of such men, and as Chairman of the Council I wish to pay to them the respect and appreciation that will ever be theirs from a grateful Society.

"Among this host of contributors to our

achievements there stands out, from time to time, one or two who have not only rendered long and exceptional services and discharged their duties faithfully, but have actually given of themselves far beyond the call of office because of the love of the work and the feeling of satisfaction in doing something more than that required for their Society, their brethren in medicine, and the people of this state.

"The Council of this Society has taken recognition of these members and from time to time wishes to bestow upon them a little token as small in intrinsic value as it is large as an emblem of the faith, high regard and affection of their fellow members.

"To Doctors Dodd, Harper, McGovern, Jermain, and Edward Evans, have we given the award,—the gold seal of our Society.

"Tonight I stand to give another and to a woman. Dr. Glasier will you arise, please.

"Mina Brooks Glasier—A daughter of Wisconsin, a teacher in its public schools, a physician for fifty years, the wife of a physician, the sister of a physician, the niece of a physician, a past worthy grand matron of the Wisconsin Order of the Eastern Star, a past president of the Grant County Medical Society and now rounding out thirty consecutive years as its Secretary; a member of the State Board of Health now in the eighth year of service, and a mother,—for your distinguished service in your home, in your profession; to your profession and to the people of this commonwealth, we, your fellow members, give you this seal of our Society as a token of your achievements and our esteem and affection."

GOLF TOURNAMENT

Over 75 members participated in the Annual Golf Tournament held at the Tripoli Country Club on Tuesday, September 13th. The golf tournament was in charge of Dr. Francis A. Thompson, chairman, Dr. Ernest W. Miller, Dr. Clyde Morter, Dr. Charles Fidler, and Dr. Francis McMahon, all of Milwaukee. Dr. S. M. Mitchell, president of the Milwaukee County Golf Association, presided at the dinner given at the Tripoli Club following the tournament.

Low Gross championship cup went to Dr. E. W. Miller of Milwaukee, who wins the cup permanently as it is his third victory—score 78.

Dr. W. M. Mitchell and Dr. E. W. Reuth, both of Milwaukee, tied for second place—score 79 gross.

Dr. G. I. Love of Oconomowoc, gross 80.

The secretary's cup went to Dr. J. C. Griffiths of Milwaukee with a net of 71.

The following doctors were in on the prizes in order named for low net scores:

Dr. R. C. Hartman
Dr. William Ryan
Dr. J. H. Jenner
Dr. W. A. Wagner
Dr. J. W. Lowe
Dr. A. M. Lindner
Dr. R. E. Fitzgerald
Dr. Clyde Morter
Dr. G. I. Hogue
Dr. Edwin C. Bach
Dr. M. J. Renker
Dr. I. A. Rosenberg
Dr. D. G. Hugo

Dr. M. E. Ross won the prize for three blind holes.

Dr. R. E. Fitzgerald won the prize for the low gross on 3–7–12– and 14, short holes.

The senior cup was won by Dr. Lewis Jermain.

The blind bogey was won by Dr. Ernest Miller, Dr. Bach, and Dr. L. Hansen.

List of Registrants at 91st Anniversary Meeting

MEMBERS—794

Adamkiewicz, J. J. ---------- Milwaukee
Adams, G. F. ---------- Kenosha
Allen, Jessie P. ---------- Beloit
Allen, J. S. ---------- Norwalk
Allen, W. J. ---------- Beloit
Altenhofen, A. R. ---------- Milwaukee
Altman, Maurice ---------- Milwaukee
Amundson, K. K. ---------- Cambridge
Andrew, C. H. ---------- Platteville
Ansfield, D. J. ---------- Milwaukee
Armstrong, C. A. ---------- Prairie du Chien
Arnold, F. W. ---------- Milwaukee
Arveson, R. G. ---------- Frederic
Ausman, D. C. ---------- Milwaukee
Aylward, T. J. ---------- Milwaukee

Bach, E. C. ---------- Milwaukee
Bach, J. A. ---------- Milwaukee

Bach, M. J. ---------- Milwaukee
Bachhuber, A. E. Sr. ---------- Mayville
Baer, C. A. ---------- Milwaukee
Balkwill, C. A. ---------- Grafton
Bannen, W. E. ---------- La Crosse
Bardeen, C. R. ---------- Madison
Bardenwerper, H. E. ---------- Milwaukee
Barnes, H. T. ---------- Delafield
Barnes, J. S. ---------- Milwaukee
Barta, E. F. ---------- Milwaukee
Barth, G. P. ---------- Milwaukee
Bassuener, R. O. ---------- Sheboygan Falls
Batty, A. J. ---------- Portage
Bauer, K. T. ---------- West Bend
Baum, E. L. ---------- Milwaukee
Baumgart, C. H. ---------- Milwaukee
Baumgartner, M. M. ---------- Janesville
Baumgarten, S. ---------- Milwaukee
Bear, W. G. ---------- Monroe
Beck, A. A. ---------- Wautoma
Becker, C. J. ---------- Milwaukee
Becker, W. C. ---------- Watertown
Beebe, C. S. ---------- Milwaukee
Beebe, S. D. ---------- Sparta
Belknap, E. L. ---------- Milwaukee
Bell, A. R. ---------- Tomah
Belting, G. W. ---------- Orfordville
Bender, B. I. ---------- Milwaukee
Benn, H. P. ---------- Stevens Point
Bennett, J. F. ---------- Burlington
Benson, G. H. ---------- Richland Center
Bentley, J. E. ---------- Portage
Benton, R. W. ---------- Milwaukee
Bentzein, E. W. ---------- Milwaukee
Berg, W. R. ---------- Gillett
Bergen, R. D. ---------- Milwaukee
Bernhard, L. A. ---------- Milwaukee
Bickel, E. F. ---------- Oshkosh
Bickler, E. P. ---------- Milwaukee
Bill, B. J. ---------- Genoa City
Biller, S. E. ---------- Milwaukee
Binnie, Helen A. ---------- Kenosha
Bird, M. D. ---------- Marinette
Birk, B. J. ---------- Milwaukee
Bitter, R. H. ---------- Oshkosh
Blackburn, F. E. ---------- Cassville
Blair, J. F. ---------- Milwaukee
Blekking, J. H. ---------- Sheboygan Falls
Blewett, M. T. ---------- Markesan
Blount, W. P. ---------- Milwaukee
Blumenthal, R. W. ---------- Milwaukee
Boley M. H. ---------- Milwaukee
Borman, M. C. ---------- Milwaukee
Borsack, K. K. ---------- Fond du Lac
Bourne, N. W. ---------- Milwaukee
Bowen, H. P. ---------- Watertown
Bowman, F. F. ---------- Madison
Boyd, C. D. ---------- Kaukauna
Boyd, G. T. ---------- Fond du Lac
Brey, P. F. ---------- Milwaukee
Brindley, B. I. ---------- Madison
Brook, J. J. ---------- Milwaukee
Brooks, E. H. ---------- Appleton
Brooks, L. M. ---------- Milwaukee
Brown, D. A. ---------- Madison
Brown, G. V. I. ---------- Milwaukee
Bruins, Dirk ---------- Milwaukee
Brumbaugh, E. V. ---------- Milwaukee
Brussock, W. A. ---------- Milwaukee
Bryan, A. W. ---------- Madison
Buckley, W. E. ---------- Racine
Buckner, H. M. ---------- Mt. Horeb
Bunting, C. H. ---------- Madison
Burbach, T. H. ---------- Milwaukee
Busse, A. A. ---------- Jefferson
Bussewitz, M. A. ---------- Milwaukee
Butler, F. E. ---------- Menomonie

Caffrey, A. J. ---------- Milwaukee
Cahana, Stephen ---------- Milwaukee
Cahoon, Roger ---------- Baraboo
Callan, P. L. ---------- Milwaukee
Calvert, Charlotte ---------- Madison
Campbell, W. B. ---------- Waukesha
Cannon, H. J. ---------- Milwaukee
Caples, B. M. ---------- Waukesha
Carhart, G. A. ---------- Milwaukee
Carns, Marie L. ---------- Madison
Carson, W. J. ---------- Milwaukee
Carter, R. M. ---------- Green Bay
Carthaus, A. H. C. ---------- Thiensville
Cary, E. C. ---------- Reedsville
Casper, S. L. ---------- Berlin
Cavaney, J. J. ---------- Milwaukee
Chamness, G. C. ---------- Racine
Chase, Estelle S. ---------- Ft. Atkinson
Christensen, F. C. ---------- Racine
Christofferson, H. H. ---------- Colby
Clark, J. F. W. ---------- Laona
Clark, W. T. ---------- Janesville
Cline, F. A. ---------- Madison
Coffey, C. J. ---------- Milwaukee
Coffey, S. E. ---------- Milwaukee
Comee, W. C. ---------- Green Bay
Comstock, Elizabeth ---------- Arcadia
Conley, J. M. ---------- Oshkosh
Conroy, C. F. ---------- Milwaukee
Connell, F. Gregory ---------- Oshkosh
Constantine, C. E. ---------- Racine
Cook, E. F. ---------- Milwaukee
Cook, H. E. ---------- Milwaukee
Cooksey, R. T. ---------- Madison
Coon, H. M. ---------- Stevens Point
Coon, W. W. ---------- Walworth
Corry, F. M. ---------- Menasha
Costello, W. H. ---------- Randolph
Cowan, W. F. ---------- Stevens Point
Cron, R. S. ---------- Milwaukee
Crosley, G. E. ---------- Milton
Cunningham, Wilson ---------- Platteville
Currer, P. M. ---------- Milwaukee
Curtin, J. G. ---------- Milwaukee
Cushing-Lippitt, Eleänore ---------- Milwaukee

Dallwig, E. L. ---------- Milwaukee
Dallwig, H. C. ---------- Milwaukee
Darby, G. S. ---------- Brodhead
Davis, Carl Henry ---------- Milwaukee
Dawson, D. L. ---------- Rice Lake
Dean, James P. ---------- Madison
Dean, Joseph ---------- Madison
Dearholt, H. E. ---------- Milwaukee
Delaney, H. O. ---------- Beloit
de Neveu, A. V. ---------- Milwaukee
De Nosaquo, S. ---------- Milwaukee
Dettmann, N. F. ---------- Wauwatosa
Devine, G. C. ---------- Ontario
Devine, H. A. ---------- Fond du Lac
Devine, J. C. ---------- Fond du Lac
Dickinson, G. H. ---------- Milwaukee
Dierker, O. F. ---------- Watertown
Dieterle, J. O. ---------- Milwaukee
Dietsch, L. C. ---------- Plymouth
Dockry, L. E. ---------- Kewaunee
Docter, John ---------- Racine
Dodd, J. M., Sr. ---------- Ashland
Doege, K. H. ---------- Marshfield
Doege, Paul F. ---------- Marshfield
Doerr, August ---------- Milwaukee
Donnelly, F. J. ---------- North Lake
Dorr, A. M. ---------- Milwaukee
Doyle, J. N. ---------- Wausau
Drew, F. E. ---------- Milwaukee
Driessel, S. J. ---------- Barton
Duer, G. R. ---------- Marinette

Dundon, J. R. ---------- Milwaukee

Echols, C. M. ---------- Milwaukee
Edwards, W. C. ---------- Richland Center
Egan, W. J. ---------- Milwaukee
Egloff, L. W. ---------- Pewaukee
Eigenberger, F. ---------- Sheboygan
Eisele, P. L. ---------- Ripon
Eisenberg, J. J. ---------- Milwaukee
Eisenberg, L. A. ---------- Milwaukee
Eisenberg, P. J. ---------- Milwaukee
Elconin, D. V. ---------- Milwaukee
Ellis, I. G. ---------- Madison
Enzer, Norbert ---------- Milwaukee
Epperson, P. S. ---------- Milwaukee
Evans, C. A. ---------- Milwaukee
Evans, E. P. ---------- Milwaukee
Evans, J. A. ---------- La Crosse
Ewell, G. H. ---------- Madison

Fain, S. C. ---------- Waukesha
Falk, V. S. ---------- Milwaukee
Farnsworth, F. B. ---------- Janesville
Farrell, F. R. ---------- Milwaukee
Fauerbach, Louis ---------- Madison
Fazen, L. E. ---------- Racine
Fechter, F. J. ---------- Milwaukee
Fellman, G. H. ---------- Milwaukee
Fencil, Y. J. ---------- Casco
Fernan-Nunez, M. ---------- Milwaukee
Festerling, E. G. ---------- Milwaukee
Fidler, Charles ---------- Milwaukee
Fiebiger, G. J. ---------- Waterloo
Fiedler, O. A. ---------- Sheboygan
Fine, J. M. ---------- Cudahy
Fisher, R. S. ---------- Allenton
Fitzgerald, G. F. ---------- Milwaukee
Fitzgerald, R. E. ---------- Milwaukee
Flarity, T. H. ---------- Beloit
Fletcher, E. A. ---------- Milwaukee
Fletcher, W. T. ---------- Salem
Flynn, R. E. ---------- La Crosse
Foerster, H. R. ---------- Milwaukee
Foerster, O. H. ---------- Milwaukee
Foley, L. J. ---------- Milwaukee
Ford, W. A. ---------- Sheboygan
Ford, W. B. ---------- Milwaukee
Forkin, G. E. ---------- Menasha
Fortier, C. A. H. ---------- Milwaukee
Foshion, H. V. ---------- Algoma
Fox, G. W., Jr. ---------- Milwaukee
Fox, M. J. ---------- Milwaukee
Fox, P. A. ---------- Beloit
Francois, S. J. ---------- New Glarus
Frederick, R. H. ---------- Milwaukee
Fredrick, H. H. F. ---------- Westfield
Fredrick, H. Y. ---------- Westfield
Freedman, John ---------- Milwaukee
Friedbacher, K. ---------- West Allis
Friend, L. J. ---------- Beloit
Froelich, J. A. ---------- Milwaukee

Gabor, M. E. ---------- Milwaukee
Gaenslen, F. J. ---------- Milwaukee
Galloway, A. D. ---------- Barron
Garens, R. W. ---------- Milwaukee
Garvey, J. L. ---------- Milwaukee
Gates, A. J. ---------- Tigerton
Gavin, S. E. ---------- Fond du Lac
Gebhard, U. E. ---------- Milwaukee
Gertenbach, E. O. ---------- Milwaukee
Gilchrist, R. T. ---------- Milwaukee
Gilmer, L. T. ---------- Milwaukee
Glasier, M. B. ---------- Bloomington
Gleason, C. M. ---------- Manitowoc
Goggins, J. W. ---------- Chilton
Goldberg, N. ---------- Milwaukee
Gonce, J. E. ---------- Madison
Gorder, A. C. ---------- Milwaukee
Gordon, J. S. ---------- Milwaukee
Gosin, F. J. ---------- Green Bay
Gramling, E. H. ---------- Milwaukee
Gramling, H. J. ---------- Milwaukee
Gramling, J. J. ---------- Milwaukee
Gray, A. W. ---------- Milwaukee
Gray, R. J. ---------- Brooklyn
Gray, W. K. ---------- Milwaukee
Greeley, H. P. ---------- Madison
Greenwood, S. D. ---------- Neenah
Greenthal, R. M. ---------- Milwaukee
Griffith, J. C. ---------- Milwaukee
Grill, John ---------- Milwaukee
Grotjan, W. F. ---------- Milwaukee
Ground, W. E. ---------- Superior
Grove, W. E. ---------- Milwaukee
Guerin, L. H. ---------- Milwaukee
Guilfoyle, J. P. ---------- Evansville
Gundersen, G. ---------- La Crosse
Gute, E. B. ---------- Milwaukee

Habbe, J. E. ---------- Milwaukee
Habeck, E. A. W. ---------- Milwaukee
Hackett, J. H. ---------- Milwaukee
Hagerman, F. H. ---------- Milwaukee
Hake, C. B. ---------- Milwaukee
Hall, R. M. ---------- Milwaukee
Hammond, A. W. ---------- Beaver Dam
Hammond, F. W. ---------- Manitowoc
Hammond, R. W. ---------- Manitowoc
Hankwitz, P. G. ---------- Milwaukee
Hansen, John ---------- Glenbeulah
Harder, Henry ---------- Milwaukee
Hardy, C. F. ---------- Milwaukee
Hargarten, L. J. ---------- Milwaukee
Harkins, J. P. ---------- Madison
Harlow, G. A. ---------- Milwaukee
Harper, C. A. ---------- Madison
Harrington, E. T. ---------- Milwaukee
Hartman, E. C. ---------- Janesville
Harvey, J. R. ---------- Footville
Hassall, J. C. ---------- Oconomowoc
Hastings, J. F. ---------- Kenosha
Haushalter, H. P. ---------- Milwaukee
Hausmann, N. E. ---------- Kewaskum
Hebenstreit, A. J. ---------- Juneau
Heiden, H. H. ---------- Sheboygan
Heidner, A. H. ---------- West Bend
Heifetz, E. C. ---------- Milwaukee
Hemmingsen, T. C. ---------- Racine
Henes, Edwin ---------- Milwaukee
Henika, G. W. ---------- Madison
Henken, J. F. ---------- Racine
Heraty, J. A. ---------- Milwaukee
Hermann, W. C. ---------- West Allis
Herner, W. L. ---------- Milwaukee
Herzog, J. V. ---------- Elkhorn
Higgins, S. G. ---------- Milwaukee
Hildebrand, G. J. ---------- Sheboygan
Hiller, R. I. ---------- Milwaukee
Hipke, G. A. ---------- Milwaukee
Hipke, L. W. ---------- Milwaukee
Hirschboeck, J. G. ---------- Forestville
Hitz, H. B. ---------- Milwaukee
Hitz, J. B. ---------- Milwaukee
Hodgson, A. J. ---------- Waukesha
Hoffmann, G. H. ---------- West Allis
Hoffmann, J. G. ---------- Hartford
Hogue, G. I. ---------- Milwaukee
Hosmer, M. S. ---------- Ashland
Howard, M. Q. ---------- Wauwatosa
Howard, T. J. ---------- Milwaukee
Hoyer, A. A. ---------- Beaver Dam
Hoyt, G. E. ---------- Milwaukee
Hughes, J. R. ---------- Milwaukee

Huston, John ---------- Milwaukee
Hyslop, V. B. ---------- Madison

Irvine, R. K. ---------- Manawa
Irwin, G. H. ---------- Lodi
Irwin, R. S. ---------- Wauwatosa

Jackson, A. S. ---------- Madison
Jackson, Edward ---------- Milwaukee
Jackson, R. H. ---------- Madison
Jamieson, G. H. ---------- Racine
Jamieson, R. D. ---------- Racine
Janney, F. R. ---------- Milwaukee
Jegi, H. A. ---------- Galesville
Jenner, J. A. ---------- Milwaukee
Jermain, H. F. ---------- Milwaukee
Jermain, L. F. ---------- Milwaukee
Jermain, W. M. ---------- Milwaukee
Johnson, A. W. ---------- Milwaukee
Johnson, C. G. ---------- Milwaukee
Johnson, F. G. ---------- Iron River
Johnston, T. L. ---------- Milwaukee
Jones, R. W. ---------- Wausau
Jones, W. J. ---------- La Crosse
Joseph, W. A. ---------- Milwaukee
Jorgenson, H. L. ---------- Kenosha
Judge, T. A. ---------- Milwaukee
Juergens, L. W. ---------- Milwaukee
Juers, R. H. ---------- Marshfield
Jurss, C. D. ---------- Milwaukee

Kahn, Joseph ---------- Milwaukee
Kane, J. J. ---------- Prairie du Chien
Karsten, J. H. ---------- Horicon
Kasak, Michael ---------- Wauwatosa
Kassowitz, K. E. ---------- Wauwatosa
Kastner, A. L. ---------- Milwaukee
Kauth, P. M. ---------- West Bend
Kearns, W. M. ---------- Milwaukee
Keenan, T. P. ---------- Lake Geneva
Keland, H. B. ---------- Racine
Kelley, J. M. ---------- Cato
Kelly, J. A. ---------- Chippewa Falls
Kenney, H. J. ---------- Delavan
Keskey, G. I. ---------- Kenosha
Kidder, E. E. ---------- Stevens Point
King, James J. ---------- Milwaukee
King, Jos. M. ---------- Milwaukee
Kissinger, C. A. ---------- Milwaukee
Klinger, George ---------- Waukesha
Knauf, F. P. ---------- Kiel
Knauf, N. J. ---------- Chilton
Knox, E. S. ---------- Green Bay
Koch, H. C. ---------- Whitehall
Koehler, J. P. ---------- Milwaukee
Kosanke, F. E. ---------- Lomira
Kohn, S. E. ---------- Milwaukee
Kradwell, W. T. ---------- Wauwatosa
Krahn, G. W. ---------- Oconto Falls
Kristjanson, H. T. ---------- Milwaukee
Kritter, F. J. ---------- Milwaukee
Kriz, G. A. ---------- Milwaukee
Krueger, Bernard ---------- Cudahy
Krygier, A. A. ---------- Milwaukee
Kuegle, F. H. ---------- Janesville
Kurten, R. M. ---------- Racine
Kusterman, A. F. ---------- Milwaukee

Lademan, O. E. ---------- Milwaukee
Ladewig, A. W. ---------- Milwaukee
Ladewig, H. C. ---------- Milwaukee
Lambert, J. W. ---------- Antigo
Landis, R. V. ---------- Appleton
Langjahr, A. R. ---------- Milwaukee
Lapp, H. D. ---------- Janesville
Lawler, T. S. ---------- Milwaukee
Leahy, J. D. ---------- Park Falls
Lechtenberg, E. H. ---------- Evansville
Le Cron, W. L. ---------- Milwaukee
Leeson, F. W. ---------- Beloit
Leicht, Phillip ---------- Lake Mills
Leitch, G. W. ---------- Milwaukee
Leonard, C. W. ---------- Fond du Lac
Lettenberger, J. ---------- Milwaukee
Lewis, Marian ---------- Milwaukee
Liefert, W. S. ---------- Milwaukee
Lieberman, B. ---------- Milwaukee
Light, George ---------- Milwaukee
Lillie, O. R. ---------- Milwaukee
Lindner, A. M. ---------- Racine
Lindsay, W. T. ---------- Madison
Linn, W. N. ---------- Oshkosh
Lipman, W. H. ---------- Kenosha
Lippitt, S. H. ---------- Milwaukee
Littig, L. V. ---------- Madison
Lobedan, E. T. ---------- Milwaukee
Long, C. W. ---------- Milwaukee
Longley, J. R. ---------- Fond du Lac
Lorenz, W. F. ---------- Madison
Lotz, Oscar ---------- Milwaukee
Loughlin, D. M. ---------- Milwaukee
Loughlin, T. F. ---------- Hartford
Love, I. B. ---------- Milwaukee
Lowe, J. W. ---------- Merrillan
Ludden, R. H. ---------- Viroqua
Lund S. O. ---------- Cumberland
Lynch, D. W. ---------- Milwaukee
Lynch, H. M. ---------- West Bend

MacGregor, J. W. ---------- Portage
MacInnis, F. E. ---------- Milwaukee
Mackoy, F. W. ---------- Milwaukee
MacLaren, J. B. ---------- Appleton
MacRae, M. F. ---------- Milwaukee
Madison, F. W. ---------- Milwaukee
Madison, J. D. ---------- Milwaukee
Malloy, T. E. ---------- Random Lake
Malnekoff, B. J. ---------- Milwaukee
Malone, J. Y. ---------- Whitefish Bay
Marek, F. B. ---------- Racine
Margoles, F. C. ---------- Milwaukee
Markson, S. M. ---------- Milwaukee
Marsh, H. E. ---------- Madison
Marshall, V. F. ---------- Appleton
Masten, M. G. ---------- Madison
Matthews, J. B. ---------- Milwaukee
Mauermann, J. F. ---------- Monroe
May, J. V. ---------- Marinette
Mayfield, A. L. ---------- Kenosha
McBeath, N. E. ---------- Milwaukee
McCabe, J. M. ---------- Sun Prairie
McCann, Edith ---------- Milwaukee
McCarthy, J. J. ---------- Sun Prairie
McDonald, R. E. ---------- Milwaukee
McGary, Lester ---------- Madison
McGovern, J. J. ---------- Milwaukee
McKillip, W. J. ---------- Milwaukee
McMahon, A. E. ---------- Glenwood City
McMahon, F. B. ---------- Milwaukee
McMahon, H. O. ---------- Milwaukee
McMahon, J. P. ---------- Milwaukee
Meany, S. G. ---------- East Troy
Megna, Salvatore ---------- Milwaukee
Mensing, E. H. ---------- Milwaukee
Metcalf, G. S. ---------- Janesville
Meusel, H. H. ---------- Oshkosh
Meyer, R. C. ---------- Plymouth
Middleton, W. S. ---------- Madison
Mieding, A. E. ---------- Milwaukee
Mielke, E. F. ---------- Appleton
Miller, E. A. ---------- Clintonville
Miller, E. W. ---------- Milwaukee
Miller, H. C. ---------- Racine
Miller, W. J. ---------- Madison

Mills, R. G. ---------- Fond du Lac
Miloslavich, E. L. ---------- Milwaukee
Minahan, J. J. ---------- Chilton
Miner, H. B. ---------- Milwaukee
Mishoff, I. D. ---------- Milwaukee
Mitchell, E. J. ---------- Brodhead
Mollinger, S. M. ---------- Milwaukee
Monsted, J. W. Jr. ---------- New London
Morter, C. W. ---------- Milwaukee
Morter, R. E. ---------- Milwaukee
Mudroch, J. A. ---------- Columbus
Mueller, J. F. ---------- Plymouth
Mueller, W. E. ---------- Green Bay
Mullen, R. A. ---------- East Troy
Mulsow, J. E. ---------- Milwaukee
Mundt, Raymond ---------- Oconomowoc
Munkwitz, F. H. ---------- Milwaukee
Murphy, F. D. ---------- Milwaukee
Murphy, J. A. ---------- Milwaukee
Murphy, W. J. ---------- Milwaukee

Nammacher, T. H. ---------- Oconomowoc
Nause, F. A. ---------- Sheboygan
Nebel, Harold ---------- Milwaukee
Neidhold, C. D. ---------- Appleton
Nelson, W. V. ---------- Milwaukee
Nesbit, M. E. ---------- Madison
Nichols, W. T. ---------- Milwaukee
Niland, P. J. ---------- Milwaukee
Nimz, F. N. ---------- La Crosse
Nixon, H. G. B. ---------- Hartland
Northey, T. M. ---------- Racine
Noble, J. B. ---------- Waukesha
Notbohm, W. R. ---------- Sullivan
Nuzum, T. O. ---------- Janesville
Nuzum, T. W. ---------- Janesville

Oberembt, B. H. ---------- Milwaukee
Oberbreckling, P. E. ---------- Milwaukee
O'Brien, G. M. ---------- South Milwaukee
O'Hara, J. J. ---------- Milwaukee
O'Hora, C. M. ---------- Beaver Dam
O'Leary, T. J. ---------- Superior
O'Leary, T. J. ---------- East Troy
Olmsted, A. O. ---------- Green Bay
Olsen, Maurice ---------- Milwaukee
Olson, H. J. ---------- Milwaukee
O'Malley, T. S. ---------- Milwaukee
O'Malley, W. P. ---------- Milwaukee
O'Neal, Orvil ---------- Ripon
O'Neill, E. J. ---------- Milwaukee
Osgood, C. W. ---------- Milwaukee

Parke, George ---------- Viola
Partridge, C. D. ---------- Cudahy
Patek, A. J. ---------- Milwaukee
Pease, W. A. ---------- Rio
Pegram, J. W. ---------- Milwaukee
Pember, A. H. ---------- Janesville
Pendergast, T. J. ---------- Milwaukee
Perlson, P. H. ---------- Milwaukee
Pessin, S. B. ---------- Madison
Peterman, M. G. ---------- Milwaukee
Peters, H. A. ---------- Oconomowoc
Peterson, C. F. ---------- Independence
Peterson, G. E. ---------- Waukesha
Peterson, L. W. ---------- Shawano
Pefferkorn, E. B. ---------- Oshkosh
Pfeifer, E. C. ---------- Racine
Pfeifer, F. J. ---------- New London
Pfeifer, H. A. ---------- Milwaukee
Pfeil, R. C. ---------- Milwaukee
Pierce, D. F. ---------- Milwaukee
Pirsch, M. V. ---------- Kenosha
Pitz, M. N. ---------- Neenah
Plahner, S. ---------- Milwaukee
Pleyte, A. A. ---------- Milwaukee
Podlasky, H. B. ---------- Milwaukee

Pomainville, F. X. ---------- Wisconsin Rapids
Pomainville, G. J. ---------- Nekoosa
Pope, F. W. ---------- Racine
Popp, Albert ---------- Milwaukee
Potter, R. P. ---------- Marshfield
Powers, H. W. ---------- Milwaukee
Pratt, G. N. ---------- Neenah
Prentice, J. W. ---------- Ashland
Prince, L. H. ---------- Waukesha
Puestow, K. L. ---------- Madison
Pugh, G. J. ---------- North Milwaukee

Quackenbush, E. C. ---------- Menasha
Quick, E. W. ---------- Milwaukee

Radloff, A. C. ---------- Plymouth
Ragan, W. F. ---------- Milwaukee
Raine, Forrester ---------- Milwaukee
Rasmussen, Hans ---------- Milwaukee
Raube, H. A. ---------- Beloit
Rauch, A. M. ---------- Kenosha
Rauch, W. A. ---------- Valders
Rauchschwalbe, L. E. ---------- Milwaukee
Raymond, R. G. ---------- Brownsville
Reay, G. R. ---------- La Crosse
Rector, A. E. ---------- Appleton
Redelings, T. J. ---------- Marinette
Rees, T. H. ---------- Manitowoc
Rehorst, J. J. ---------- Fond du Lac
Reich, W. F. ---------- Milwaukee
Reinke, C. C. ---------- Milwaukee
Rhea, C. W. ---------- Waukesha
Rheineck, A. F. ---------- Milwaukee
Richards, C. G. ---------- Kenosha
Ringo, H. F. ---------- Montreal
Riopelle, W. G. ---------- Beaver Dam
Ripley, H. M. ---------- Kenosha
Ritchie, G. A. ---------- Appleton
Roberts, D. W. ---------- Milwaukee
Rock, J. N. ---------- Milwaukee
Rodecker, R. C. ---------- Mercer
Rogers, A. W. ---------- Oconomowoc
Rogers, E. H. ---------- Milwaukee
Rogers, M. F. ---------- Milwaukee
Rogers, R. B. ---------- Neenah
Rolfs, T. H. ---------- Milwaukee
Ross, M. E. ---------- Brodhead
Roth, W. C. ---------- Racine
Rothenmaier, G. L. ---------- Elkhart Lake
Rudolf, A. J. ---------- Milwaukee
Rueth, J. E. ---------- Milwaukee
Ruschaupt, L. F. ---------- Milwaukee
Russell, J. A. ---------- Milwaukee
Russell, R. J. M. ---------- Milwaukee
Ryan, C. E. ---------- Appleton
Ryan, E. R. ---------- Milwaukee
Ryan, W. A. ---------- Milwaukee

Salinko, S. S. ---------- Milwaukee
Sander, O. A. ---------- Milwaukee
Sargent, J. C. ---------- Milwaukee
Sayle, R. G. ---------- Milwaukee
Scantleton, J. M. ---------- Sparta
Schacht, R. J. ---------- Racine
Schaefer, A A. ---------- Milwaukee
Schaefer, C. O. ---------- Racine
Schelble, E. J. ---------- Milwaukee
Schell, I. L. ---------- Milwaukee
Schiek, I. E. ---------- Rhinelander
Schiller, L. ---------- Milwaukee
Schlaepfer, K. ---------- Milwaukee
Schloemer, A. J. ---------- Jackson
Schlomovitz, B. H. ---------- Milwaukee
Schlomovitz, E. H. ---------- Milwaukee
Schlomovitz, H. H. ---------- Barron
Schlossmann, B. ---------- South Milwaukee
Schlueter, U. A. ---------- Milwaukee
Schmidt, E. R. ---------- Madison

Schmidt, E. S. ---------- Green Bay
Schmidt, H. G. ---------- Milwaukee
Schmidt, J. A. ---------- Milwaukee
Schmit, Felix ---------- Milwaukee
Schneider, C. C. ---------- Milwaukee
Schneller, E. J. ---------- Racine
Scholter, E. A. W. ---------- Milwaukee
Scholz, G. M. ---------- Milwaukee
Scholz, H. F. ---------- Thiensville
Schowalter, R. P. ---------- Milwaukee
Schram, C. F. N. ---------- Beloit
Schulz, G. J. ---------- Milwaukee
Schulz, Irwin ---------- Milwaukee
Schulz, J. H. A. ---------- Milwaukee
Schumacher, H. S. ---------- Milwaukee
Schumm, H. C. ---------- Milwaukee
Schutte, A. G. ---------- Milwaukee
Schweitzer, G. J. ---------- Milwaukee
Scollard, J. T. ---------- Milwaukee
Scollard, W. J. ---------- Milwaukee
Seaman, G. E. ---------- Milwaukee
Searle, D. R. ---------- Superior
Seeger, S. J. ---------- Milwaukee
Seegers, F. W. ---------- Milwaukee
Seelman, J. J. ---------- Milwaukee
Senn, Ulrich ---------- Milwaukee
Sevringhaus, E. L. ---------- Madison
Shapiro, Harry ---------- Adams
Shaw, B. W. ---------- Waunakee
Shearer, H. A. ---------- Beloit
Sherwood, M. W. ---------- Milwaukee
Shimpa, J. F. ---------- Milwaukee
Shutter, H. W. ---------- Milwaukee
Sickles, W. A. ---------- South Milwaukee
Sieker, A. W. ---------- Plymouth
Silbar S. J. ---------- Milwaukee
Simenstad, L. O. ---------- Osceola
Sisk, J. N. ---------- Madison
Sivyer, A. W. ---------- Milwaukee
Skemp, G. E. ---------- La Crosse
Skwor, C. J. ---------- Mishicot
Slaney, A. F. ---------- Hilbert
Sleyster, Rock ---------- Wauwatosa
Smiles, C. J. ---------- Ashland
Smith, C. E. ---------- Beloit
Smith, E. A. ---------- Milwaukee
Smith, H. S. ---------- Cudahy
Smith, J. F. ---------- Wausau
Smith, J. W. ---------- Milwaukee
Smith, L. D. ---------- Milwaukee
Smith, R. C. ---------- Superior
Smith, S. M. B. ---------- Wausau
Smith, Woodruff ---------- Ladysmith
Snodgrass, T. J. ---------- Janesville
Smuckler, R. H. ---------- Milwaukee
Spilberg, S. B. ---------- Milwaukee
Spitz, M. M. ---------- Milwaukee
Sprague, L. V. ---------- Madison
Sproule, R. P. ---------- Milwaukee
Squier, T. L. ---------- Milwaukee
Squire, C. A. ---------- Sheboygan
Stamm, L. P. ---------- Milwaukee
Stang, H. M. ---------- Eau Claire
Stannard, G. H. ---------- Sheboygan
Stauff, G. R. ---------- Birnamwood
Stebbins, G. G. ---------- Madison
Steele, G. A. ---------- Oshkosh
Stein, J. F. ---------- Oshkosh
Stemper, I. ---------- Oconomowoc
Stewart, W. C. ---------- Kenosha
Stiehm, R. H. ---------- Milwaukee
Stockinger, R. E. ---------- Milwaukee
Stoddard, C. H. ---------- Milwaukee
Stovall, W. D. ---------- Madison
Stranberg, W. L. ---------- West Allis
Stratton, F. A. ---------- Milwaukee
Stubenvoll, C. E. ---------- Shawano
Studley, W. H. ---------- Milwaukee
Stueck, A. F. ---------- Manitowoc
Sure, J. H. ---------- Milwaukee
Swanton, M. E. ---------- Appleton
Sykes, H. D. ---------- Milwaukee
Szlapka, T. L. ---------- Milwaukee

Tabachnick, H. ---------- Milwaukee
Tanner, J. W. ---------- Eau Claire
Taugher, V. J. ---------- Milwaukee
Taylor, J. Gurney ---------- Milwaukee
Tenney, H. K. ---------- Madison
Thayer, F. A. ---------- Beloit
Thielke, G. A. ---------- Wausau
Thill, D. P. ---------- Milwaukee
Tibbitts, U. J. ---------- Waukesha
Tisdale, L. C. ---------- Milwaukee
Thompson, A. S. ---------- Mt. Horeb
Thompson, E. X. ---------- Milwaukee
Thompson, F. A. ---------- Milwaukee
Thompson, I. F. ---------- Racine
Thorndike, W. ---------- Milwaukee
Toepfer, R. A. ---------- West Allis
Tolan, T. L. ---------- Milwaukee
Tormey, A. R. ---------- Madison
Truitt, J. W. ---------- Milwaukee
Tufts, M. ---------- Milwaukee
Twohig, D. J. ---------- Fond du Lac
Twohig, J. E. ---------- Fond du Lac

Urdan, B. E. ---------- Milwaukee

Van Altena, L. A. ---------- Cedar Grove
Van Hecke, D. S. ---------- Phillips
Van Kirk, F. W. ---------- Janesville
Van Valin, E. C. ---------- Sussex
Van Zanten, W. ---------- Sheboygan
Vedder, J. B. ---------- Marshfield
Vingom, C. O. ---------- Madison
Vogel, C. C. ---------- Elroy
Vogel, T. L. ---------- Milton Junction

Wagner, N. B. ---------- Racine
Wagner, P. C. ---------- Milwaukee
Waite, W. S. ---------- Watertown
Waldeck, E. A. ---------- Milwaukee
Walters, D. N. ---------- Fond du Lac
Walters, H. G. ---------- Racine
Walton, W. B. ---------- Milwaukee
Warfield, L. M. ---------- Milwaukee
Warnshuis, G. J. ---------- Cedarburg
Washburne, A. C. ---------- Madison
Watson, E. L. ---------- Columbus
Webb, E. P. ---------- Beaver Dam
Webb, H. E. ---------- Milwaukee
Weber, A. J. ---------- Milwaukee
Weber, C. J. ---------- Sheboygan
Wegmann, N. J. ---------- Milwaukee
Wehle, W. J. ---------- West Bend
Weingart, W. F. ---------- Milwaukee
Welsh, S. M. ---------- La Crosse
Wenn, J. F. ---------- Milwaukee
Wenstrand, D. E. W. ---------- Milwaukee
Werner, C. F. ---------- St. Cloud
Werner, H. C. ---------- Mendota
Weston, F. L. ---------- Madison
Wetzler, S. H. ---------- Milwaukee
Wheeler, R. M. ---------- Madison
Wheeler, W. P. ---------- Oshkosh
Wieder, L. M. ---------- Milwaukee
Wiese, M. E. J. ---------- Milwaukee
Wiesen, R. P. ---------- Milwaukee
Wiesender, A. J. ---------- Berlin
Wiley, F. S. ---------- Fond du Lac
Wilkinson, J. D. ---------- Oconomowoc
Wilkinson, J. F. ---------- Oconomowoc
Willett, Thomas ---------- Milwaukee
Wilson, R. F. ---------- Beloit

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PRESS SERVICE OF STATE MEDICAL SOCIETY

No serum does so much for public health as printer's ink

SCHOOL AGE DEFECTS

Madison, Wis., Sept. 1.—For thousands of children in Wisconsin this month will be one of the most important in their lives. They will be sent out to school. If the care and treatment received by them promotes their physical well-being, life in the future will be happier, according to the bulletin of the State Medical Society issued today.

"Wise parents know that they can not depend upon their own judgment to decide the youngster's physical fitness," declares the bulletin issued by the State Medical Society today. "The family doctor and dentist are the ones to consult in this vital matter. The sooner defects are found, the sooner a child will be unburdened of them and start on his joyful, happy day.

"Incidentally, there are two of the communicable diseases against which the doctor can protect the small adventurer before he begins his new life in a new, big world. They are diphtheria and smallpox. If he has not already received toxin-antitoxin and been vaccinated, his moher nd dad should certainly have this done *now! now!*

"When your Johnny struts off to tackle his job this September, will he be equal to it? Not if his eyes have to strain to see blackboard or book; not if his ears can hear his teacher only when she speaks 'in a high voice'. Not if his tecth ache from neglect or his 'tummy' aches from a dozen combined causes. Not if a physical defect is dragging him down.

"Rather, he should start to school a veritable dynamo of energy. If he is perfectly normal, he will. Then school will not be a daily grind to him, something to be endured, and shirked if possible. It will be a place where he will naturally and easily rub shoulders and swap marbles with other children; keep up or surpass in studies; and make the most of education.

"Decayed teeth are likely to be sore and to cause children to chew their food improperly, thus resulting in insufficient nournishment. Poisonous pus from 'gumboils', when absorbed into the blood, may make a child tired or irritable, prevent gain in weight and reduce resistance to diseasc.

"Defective eyesight, as such, is not always noticeable in small children but reveals itself in reddened and watery eyelids, persistent headaches, strained posture, nausea, or irritability. 'No child can be optimistic with misty optics.'

"Poor posture may cause abdominal, chest or limb pains, backache or irritability.

"Hearts impaired from acute illnesses can not be replaced or remade, but the doctor can advise ways to live and play within their limitations and to prevent further injury.

"Imperfect hearing is not always permanent. Correction is sometimes possible if treatment is begun early.

"Overweight or underweight, while sometimes normal for certain families, usually indicates faulty nutrition or endocrine defects, either of which may become a serious handicap in later life.

"Mental or so-called 'nervous' defects, if present, are the greatest obstacles of all to the child. Minor ones are easily corrected, however, and major ones can almost always be improved."

* * *

THE FIRST TEETH

Madison, Wis., Sept. 8.—A receding chin does not betray a weak character but in a great majority of cases it is an indication that the person did not have proper attention to teeth during childhood. The Educational Committee of the State Medical Society today says that the pointed chin is shaped by the loss of certain teeth during childhood and is not an evidence of weakness.

"Whatever the receding chin may, or may not, indicate relative to character, the dentist would be correct in diagnosing the condition in a majority of cases as being the result of the early loss of the first permanent molar teeth, sometimes termed the sixth-year molar," declares the bulletin.

"Early loss of the first permanent molar teeth in the lower jaw produces that rabbit chin appearance which is so often seen in adults. Once the teeth are lost, a vacant space remains, the jaw fails to grow at this point, the front teeth tilt backward and the usefulness of the entire dental arch is permanently impaired.

"When the child is about six years old, there comes in both upper and lower jaws an important tooth, often called the keystone of the dental arch. This is the sixth-year molar, the sixth tooth back from the center of the dental arch, one on either side above and below. They are the first permanent teeth to erupt and come in back of the last 'baby tooth' which often causes them to be mistaken for a temporary tooth.

"The sixth-year molar does not shed; it should last a lifetime; upon its care and preservation depends to a great extent the regularity of all the second teeth. It acts as a guide to hold the jaws in proper relation while the temporary teeth in front of it are being shed and replaced by permanent ones.

"Parents too often fail to recognize the sixth-year molar as permanent and allow the child's tooth to be lost through decay. It is likely to decay because it has pits and fissures on its surface which are very deep and hard to keep clean.

"Much of this danger may be avoided if the parents will watch for the appearance of these first permanent molars between the fifth and seventh years; have them examined for decay as soon as they appear; see that the child's food contains enough mineral, lime and phosphorus to build strong teeth; give them some coarse foods to polish the teeth and exercise the jaws, and see that they are brushed with religious regularity.

"The sixth-year molar, the keystone of the dental arch, is of priceless value to those who would enjoy good teeth in later years. They should be guarded as dearly as a precious gem."

* * *

CARE OF SCHOOL AGE CHILDREN

Madison, Wis., Sept. 15.—Before the end of the month, more than 800,000 young people will have entered the schools of Wisconsin. Probably 500,000 of these are already in school. Wisconsin's greatest health problem is the care of these children, according to the advice given by the health committee of the State Medical Society in a bulletin issued today.

"Every child entering school this fall has a better opportunity for advancement than those who have gone before, because of the improved health conditions," declares the bulletin. "If you want your child to stand high in his classes, health rules must be observed.

"Most mothers dread to see the youngsters start school because they fear it will mean a round of measles, whooping cough, colds and maybe diphtheria.

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THE JOURNAL BOOK SHELF

1931 Collected Papers of the Mayo Clinic. Volume XXIII. Edited by Mrs. Maud H. Mellish-Wilson and Richard M. Hewitt, B. A. M. A., M. D. Octavo volume of 1231 pages with 265 illustrations. Price $13.00 net. W. B. Saunders Company, Philadelphia, 1932.

Diseases of the Coronary Arteries. By Don C. Sutton, M. S., M. D., associate professor of medicine, Northwestern University; attending physician, Cook County Hospital; Chief of Cardiac Follow-Up Clinic, Cook County Hospital, Chicago, and Harold Lueth, Ph. D., M. D., formerly instructor in physiology, Northwestern University, Chicago.

Electrosurgery. By Howard A. Kelly, M. D., Baltimore, Md., and Grant E. Ward, M. D., Baltimore. 305 pages with 382 illustrations. Price $13.00 net. W. B. Saunders Company, Philadelphia, 1932.

Minor Surgery of the Urinary Tract. By Herman C. Bumpus, Jr., Ph. B., M. D., in urology, F. A. C. S., section on urology, the Mayo Foundation. Octavo of 124 pages with 57 illustrations. Price $3.00 net. W. B. Saunders Company, Philadelphia, 1932.

"Human Sterilization," J. H. Landman, Ph D., J. D., The Macmillan Co., New York (Publishers)—1932.

BOOKS RECEIVED FOR REVIEW

Posture. Its Relation to Health. By Frank D. Dickson, M. D., orthopedic surgeon, Saint Luke's Hospital of the Kansas City General Hospital, Kansas City, Mo. 118 Illustrations. Price $5.00. J. B. Lippincott Company, Philadelphia and London.

Orthopedics In Childhood. By William L. Sneed, M. D., attending surgeon, Hospital for the Relief of the Ruptured and Crippled; Fifth Avenue Hospital; consulting surgeon, French Hospital; Nassau County and North Shore Community Hospitals; instructor, Applied Anatomy Cornell Medical College. 145 illustrations. Price $5.00. J. B. Lippincott Company, Philadelphia, and London.

Gastro-intestinal Tract. By William Gerry Morgan, M. D., professor of gastroenterology, Georgetown University Medical School; consulting physician, Georgetown University Hospital, Garfield Memorial Hospital, and Gallinger Hospital, Washington, D. C. 32 illustrations. Price $5.00. J. B. Lippincott Company, Philadelphia and London.

Functional Disturbances of the Heart. By Harlow Brooks, M. D., attending physician, Fourth Medical Service, Bellevue Hospital; consulting physician, City Hospital, Montefiore Hospital, Beth Israel Hospital; St. Vincent's Hospital, Fifth Avenue Hospital. Price $5.00. J. B. Lippincott Company, Philadelphia and London.

The International Medical Annual. A year book of treatment and practitioner's index. Editors: Carey F. Coombs, M. D., A. Rendle Short, M. D. William Wood and Company, New York.

Essentials of Pediatric Nursing. By Ruth Alice Perkins, R. N., graduate of Children's Memorial School of Nursing, Chicago. Illustrated with 55 engravings in the text and 6 full page colored plates. Second edition revised and enlarged. F. A. Davis Company, Philadelphia, 1932.

The Sputum. Its examination and clinical significance. By Randall Clifford, M. D., associate in medicine, Peter Bent Brigham Hospital; assistant in medicine, Harvard Medical School; formerly associate physician and director of pulmonary clinic, Massuchusetts General Hospital. Price $4.00. The Macmillan Company, New York, 1932.

Clinical Endocrinology of the Female. By Charles Mazer, M. D., assistant professor of gynecology and obstetrics, Graduate School of Medicine, University of Pennsylvania; gynecologist to Mt. Sinai and to Northern Liberties Hospitals, Philadelphia, and Leopold Goldstein, M. D., demonstrator of obstetrics, Jefferson Medical College. Illustrated. W. B. Saunders Company, Philadelphia, 1932.

Physical Therapeutic Technic. By Frank Butler Granger, A. B., M. D., late physician-in-chief, Department of Physical Therapy, Boston City Hospital; director of Physical Therapy, United States Army; medical counselor, United States Veterans' Bureau; member of Council on Physical Therapy, American Medical Association. W. B. Saunders Company, Philadelphia and London.

Minor Surgery. By Frederick Christopher, S.B., M.D., assistant professor of surgery at the Northwestern University Medical School, Chicago; attending surgeon at the Evanston (Ill.) Hospital. Second edition, reset. With 687 illustrations. Price $10.00. W. B. Saunders Company, Philadelphia and London.

A Text-Book of Pathology. By William Boyd, M. D., professor of pathology in the University of Manitoba; pathologist to the Winnipeg General Hospital, Winnipeg, Canada. Illustrated with 287 engravings. Price $10.00. Lea and Febiger, Philadelphia, 1932.

BOOK REVIEWS

Any scientific publication reviewed in this column may be obtained for inspection. Orders for such inspection should be directed to the Medical Library Service, 424 N. Charter Street, Madison, Wis.

Physical Therapeutic Technic. By Frank Butler Granger, A. B., M. D., late physician-in-chief, Department of Physical Therapy, Boston City Hospital; director of Physical Therapy, United States Army; medical counselor, United States Veterans' Bureau; Member of Council on Physical Therapy,

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American Medical Association. W. B. Saunders Company, Philadelphia, and London.

Dr. Granger's long experience in physical therapy, and his connection with the surgeon's office during the World War, fit him admirably for this practical and interesting work on the theory and technique of physical therapy measures. The book is filled with helpful suggestions and practical information, such as is needed by every physician who makes use of physical measures in the treatment of disease. Dr. Granger's attitude is conservative and reasonable, and there is the absence of hyperenthusiastic statements so common in earlier books on physical therapy.

The subjects discussed include electro-physics, the various electric currents, heat and light, hydrotherapy, massage, and the indications for such forms of treatment. Emphasis is placed on technique, and valuable suggestions along these lines are discussed from his own practical experience. This second edition of the work deserves a place in every physician's library. J. C. E.

Minor Surgery. By Frederick Christopher, S. B., M. D. Assistant professor of surgery at the Northwestern University Medical School, Chicago; attending surgeon at the Evanston (Ill.) Hospital. Second edition, reset. With 687 illustrations. Price $10.00. W. B. Saunders Company, Philadelphia, 1932.

This volume has been designed to meet the needs of the general practitioner and the hospital interne. It covers the field of minor surgery. The details of procedures which are so often missing are presented very clearly. It is well illustrated and presents the subject matter very clearly. An important chapter deals with the duties of the interne and also the duties of the visiting staff. It is a worthwhile book for the library of any practitioner of medicine today. E. R. S.

PRESS SERVICE

(Continued from page 731)

Diphtheria they need not have if the parents will see that they are protected by toxin-antitoxin. And so far as the usual run of children's diseases are concerned a healthy body will be a great aid to the child in resisting the inevitable contacts. Infected tonsils, adenoids, infected teeth,—these and other conditions that cause a run-down child or one who is never quite 'top-notch' are factors that are predisposing towards the picking up of infectious disease.

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(Continued from page 730)

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Program for Inter-State Post-Graduate Medical Association at Indianapolis October 24-28

MONDAY, OCTOBER 24TH

8:00 A. M.

Diagnostic Clinic (Surgical)
Dr. Edward W. Archibald, Professor of Surgery and Director of the Department, McGill University Faculty of Medicine, Montreal, Canada.

Diagnostic Clinic (Medical)
Dr. R. W. Scott, Professor of Clinical Medicine, Western Reserve University School of Medicine, Cleveland, Ohio.

Diagnostic Clinic (Surgical)
Dr. E. Starr Judd, Professor of Surgery, University of Minnesota Graduate School of Medicine, Mayo Clinic, Rochester, Minn.

Intermission for Review of Exhibits

Diagnostic Clinic (Medical)
Dr. O. H. Perry Pepper, Professor of Clinical Medicine. University of Pennsylvania School of Medicine, Philadelphia, Pa.

Diagnostic Clinic (Surgical)
Dr. John M. T. Finney, Professor of Surgery, Johns Hopkins University School of Medicine, Baltimore, Md.

Diagnostic Clinic (Surgical)
Dr. Donald C. Balfour, Professor of Surgery, University of Minnesota Graduate School of Medicine, Mayo Clinic, Rochester, Minn.

Noon Intermission

1:00 P. M.

Diagnostic Clinic (Medical)
Dr. Elsworth S. Smith, Professor Emeritus of Clinical Medicine, Washington University School of Medicine, St. Louis, Mo.

Gall-Bladder and Liver

Address: "Surgical Lesions of the Common and Hepatic Ducts".
Dr. Howard M. Clute, Lahey Clinic, Boston, Mass.

PHYSICIANS' EXCHANGE

Advertisements for this column must be received by the 25th of the month preceding month of issue. A charge is made of $2.00 for the first appearance of copy occupying 1 inch or less of space and $1.00 for each succeeding insertion of the same copy. Kindly accompany copy with remittance to cover number of insertions desired. Advertisements from members of the State Medical Society will be accepted without charge. Such copy will be taken out after its second publication unless otherwise requested. Where numbers follow advertisements replies should be addressed care Wisconsin Medical Journal.

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WANTED: Used diathermy, Morse wave generator, infra red and quartz lamps, electric centrifuge, colorimeter and skeleton or parts. C. J. Yeager, 4 S. Genesee St., Waukegan, Illinois. ASO

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FOR SALE: X-Ray apparatus, motor driven tilt table KK, Bucky diaphragm, 5" gap, 30 M.A. x-ray machine, x-ray filing cabinet, basal metabolism machine, home model quartz lamps, infra red lamps, cassettes and screens. Will sell separately. Diagnostic Laboratories, Waukegan, Illinois. ASO

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WANTED TO BUY SOON—Good established practice. Give complete details first letter. Address No. 892 in care of the Journal. OND

FOR SALE—Will sell for cash the following: Betz metal electric light bath cabinet, $50.00, cost $300.00; bacteriological incubator, $10.00, cost $35.00; massage table, $15.00, cost $65.00. Allison office table, $35.00, cost $75.00; operating table, $10.00; cystoscope, $25.00; Rochester case of electric diagnostic instruments, $15.00; Victor high frequency coil, No. 7, $25.00, cost $200.00; autocondension couch, $10.00; three Simmons hospital beds; 2 in. tubing; 50 lb. mattress, each $12.50, and one such bed with back rest, $15.00; or all four beds for $50.00; new Spencer microscope, three objectives, Alcoe Co., No. 84368, and bell jar, $60.00, cost $130.00; Israel Carmody suction apparatus for tonsil work, $50.00, cost $95.00; Victor lead protective screen, $25.00; one Coolidge X-Ray tube, medium focus, $20.00 and two 7 in. gas tubes, Green & Bauer, each $10.00; steel office safe, 26 in. high, $15.00, cost $45.00; Koster blood transfusion apparatus, $5.00; hand centrifuge for urinalysis, $1.50; human skeleton, French, articulated and cheap wooden cabinet, $35.00; Faught sphygmomanometer, $5.00; McIntosh No. 6 plate style "A" wall cabinet $15.00, cost $60.00, and McIntosh rectifier, $5.00, cost $25.00; two microtomes, each, $2.50; Von Fleischl's hamometer, $2.50, cost $24.00; Nicholas Senn operating table, $20.00; surgical instruments and splints at less than half of present price. Address number 883 in care of Journal.

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Dr. E. Starr Judd, Rochester, Minn.

Address: "Modern Concepts in the Management of Cardiovascular Diseases".
Dr. R. W. Scott, Cleveland, Ohio.

Intermission for Review of Exhibits

Address: "The Surgical Treatment of Pulmonary Tuberculosis".
Dr. Edward W. Archibald, Montreal, Canada.

Address: "Comments on the Group of Diseases Attributed to Filterable Viruses".
Dr. O. H. Perry Pepper, Philadelphia, Pa.

Address: "Prognosis and Treatment of Ambulatory Cases Presenting the Anginoid Syndrome".
Dr. Elsworth S. Smith, St. Louis, Mo.

Dinner Intermission

7:00 P. M.

Address: "Surgical Treatment of Ulcer".
Dr. Donald C. Balfour, Rochester, Minn.

Address: "Diagnosis and Surgical Treatment of Cancer of the Stomach".
Dr. John M. T. Finney, Baltimore, Md.

Oto-Laryngology

Address: "Medical Treatment of the Diseases of the Ear, Nose and Throat".
Dr. Perry G. Goldsmith, Professor of Oto-Laryngology, University of Toronto Faculty of Medicine, Toronto, Canada.

Address: "Cancer of the Larynx".
Dr. Fielding O. Lewis, Professor of Laryngology, Jefferson Medical College, Philadelphia, Pa.

TUESDAY, OCTOBER 25TH

8:00 A. M.

Diagnostic Clinic (Surgical)
Dr. George P. Muller, Professor of Clinical Surgery, University of Pennsylvania School of Medicine, Philadelphia, Pa.

Diagnostic Clinic (Medical)
Dr. David P. Barr, Professor of Medicine, Washington University School of Medicine, St. Louis, Mo.

Diagnostic Clinic (Gynecological)
Dr. John R. Fraser, Professor of Obstetrics and Gynecology, McGill University Faculty of Medicine, Montreal, Canada.

Intermission

Diagnostic Clinic (Surgical)
Dr. Frank H. Lahey, Lahey Clinic, Boston, Mass.

Diagnostic Clinic (Medical)
Dr. Lewellys F. Barker, Professor Emeritus of Medicine, Johns Hopkins University School of Medicine, Baltimore, Md.

Diagnostic Clinic (Surgical)
Dr. Eugene H. Pool, Clinical Professor of Surgery, Columbia University College of Physicians and Surgeons, New York, N. Y.

Noon Intermission

1:00 P. M.

Diagnostic Clinic (Medical)
Dr. Warfield T. Longcope, Professor of Medicine, Johns Hopkins University School of Medicine, Baltimore, Md.

The Abdomen

Address: "The Importance of Roentgenological Studies of the Right Upper Abdominal Quadrant".
Dr. James M. Martin, Professor of Radiology, Baylor University School of Medicine, Dallas, Texas.

Address: "The Acute Abdomen".
Dr. George P. Muller, Philadelphia, Pa.

Address: "Surgery of the Spleen".
Dr. Eugene H. Pool, New York, N. Y.

Intermission

Address: "The Effects of Diseases of the Thyroid Gland on the Heart".
Dr. David P. Barr, St. Louis, Mo.

Address: "The Treatment of Hyperthyroidism".
Dr. Frank H. Lahey, Lahey Clinic, Boston, Mass.

Address: "Parathyroidism".
Dr. Max Ballin, Head of the Surgical Department, Harper Hospital, Detroit, Michigan.

Dinner Intermission

7:00 P. M.

Address: "Significance of Chronic Pelvic and Abdominal Pain in Women".
Dr. John R. Fraser, Montreal, Canada.

Address: "The Senile Patient".
Dr. Lewellys F. Barker, Baltimore, Md.

Address: "Diseases of the Skin Due to Animal Parasites".
Dr. Frank C. Knowles, Professor of Dermatology, Jefferson Medical College, Philadelphia, Pa.

Address: "Different Types of Hernia and their Treatment".
Dr. Arthur Dean Bevan, Chicago, Illinois.

Motion Picture: "Cardiac, Vasomotor and Respiratory Phenomena with an Analysis of the Signs and Symptoms of Experimentally Raised Intracranial Pressure".
A talking motion picture prepared by Professor Anton J. Carlson and Professor Arno B. Luckhardt, Department of Physiology, University of Chicago, under a special grant from Petrolagar Laboratories

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WEDNESDAY, OCTOBER 26TH

8:00 A. M.

Diagnostic Clinic (Medical)
Dr. Cyrus C. Sturgis, Professor of Internal Medicine, University of Michigan Medical School, Ann Arbor, Michigan.

Diagnostic Clinic (Surgical)
Dr. Irvin Abell, Clinical Professor of Surgery, University of Louisville School of Medicine, Louisville, Ky.

Diagnostic Clinic (Pediatric)
Dr. Alan G. Brown, Professor, Diseases of Children, University of Toronto Faculty of Medicine, and Physician-in-Chief, Hospital for Sick Children, Toronto, Canada.

Intermission

Diagnostic Clinic (Surgical)
Dr. Arthur Dean Bevan, Chairman of the Department of Surgery, Rush Medical College of the University of Chicago, Chicago, Ill.

Diagnostic Clinic (Pediatric)
Dr. William McKim Marriott, Professor of Pediatrics and Dean, Washington University School of Medicine, St. Louis, Mo.

Diagnostic Clinic (Surgical)
Dr. John F. Erdmann, Professor of Surgery, Columbia University, and Director of Surgery, Post Graduate Hospital of Columbia University, New York, N. Y.

Noon Intermission

1:00 P. M.

Diagnostic Clinic (Pediatric)
Dr. Harold B. Cushing, Clinical Professor of Pediatrics, McGill University Faculty of Medicine, Montreal, Canada.

Diagnostic Clinic (Surgical)
Dr. Dean D. Lewis, Professor of Surgery, Johns Hopkins University School of Medicine, Baltimore, Md.

Moving Picture Demonstration: "Ureterosigmoidal Transplantation" and presentation of cases by lantern slides.
Dr. Waltman Walters, Associate Professor of Surgery, University of Minnesota Graduate School of Medicine, Mayo Clinic, Rochester, Minn.

Address: "Pernicious Anemia".
Dr. Cyrus C. Sturgis, Ann Arbor, Michigan.

Intermission

Intestines

Address: "Non-Specific Granuloma of the Gastro-Intestinal Tract".
Dr. John F. Erdmann, New York, N. Y.

Address: "The Diagnosis and Treatment of Diverticulitis and Diverticulosis of the Colon".
Dr. Irvin Abell, Louisville, Ky.

Address: "Constipation".
Dr. Warfield T. Longcope, Baltimore, Md.

Dinner Intermission

7:00 P. M.

Address: "The Present Status of Surgery of the Vascular System".
Dr. Dean D. Lewis, Baltimore, Md.

Pediatrics

Address: "Poliomyelitis".
Dr. William McKim Marriott, St. Louis, Mo.

Address: "Common Errors in the Diagnosis and Treatment of Children's Diseases".
Dr. Alan G. Brown, Toronto, Canada.

Address: "The Diagnosis of Some of the Contagious Diseases in Children".
Dr. Harold B. Cushing, Montreal, Canada.

THURSDAY, OCTOBER 27TH

8:00 A. M.

Diagnostic Clinic (Surgical)
Dr. John J. Moorhead, Professor of Surgery, New York Post-Graduate Medical School, Columbia University, New York, N. Y.

Diagnostic Clinic (Urological)
Dr. William E. Lower, Cleveland Clinic, Cleveland, Ohio.

Diagnostic Clinic (Medical)
Dr. Charles A. Elliott, Professor of Medicine, Northwestern University School of Medicine, Chicago, Illinois.

Intermission

Diagnostic Clinic (Urological)
Dr. Hugh H. Young, Clinical Professor of Urology, Johns Hopkins University School of Medicine, Baltimore, Md.

Diagnostic Clinic (Surgical)
Dr. William Darrach, Dean Emeritus and Professor of Clinical Surgery, Columbia University College of Physicians and Surgeons, New York, N. Y.

Diagnostic Clinic (Medical)
Dr. Campbell P. Howard, Professor of Medicine, McGill University Faculty of Medicine, Montreal, Canada.

Noon Intermission

1:00 P. M.

Diagnostic Clinic (Urological)
Dr. Hugh Cabot, Mayo Clinic, Rochester, Minn.

Address: "The Leukemias—Their Significance and their Treatment". Dr. Charles A. Elliott, Chicago, Ill.

Address: "The Teaching of Ophthalmology in this Country".
Dr. Walter R. Parker, Emeritus Professor of Ophthalmology, University of Michigan Medical School, Ann Arbor, Mich.

Intermission

Address: "A More Hopeful Outlook for the Prostatic".
Dr. William E. Lower, Cleveland, Ohio.

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Dr. Joseph F. McCarthy, Director and Professor, Department of Urology, New York Post-Graduate Medical School, Columbia University, New York, N. Y.

Address: "Recent Progress in Renal Surgery".
Dr. Hugh H. Young, Baltimore, Md.

Address: "The Problems of Drainage in Preparation for Operations for Prostatic Obstruction".
Dr. Hugh Cabot, Mayo Clinic, Rochester, Minn.

Dinner Intermission

7:00 P. M.

Bones and Joints

Address: "Critical Review of the Treatment of Fractures".
Dr. William Darrach, New York, N. Y.

Address: "Chronic Arthritis".
Dr. Edwin W. Ryerson, Professor of Orthopedic Surgery, Northwestern University Medical School, Chicago, Ill.

Address: "The Treatment of Automobile Injuries".
Dr. John J. Moorhead, New York, N. Y.

Address: "The Etiology and Treatment of Nephritis".
Dr. Campbell P. Howard, Montreal, Canada.

FRIDAY, OCTOBER 28TH

8:00 A. M.

Diagnostic Clinic (Medical)
Dr. Emanuel Libman, Professor of Clinical Medicine, Columbia University College of Physicians and Surgeons, New York, N. Y.

Diagnostic Clinic (Surgical)
Dr. George W. Crile, Cleveland Clinic, Cleveland, Ohio.

Diagnostic Clinic (Medical)
Dr. Henry A. Christian, Hersey Professor of the Theory and Practice of Physic, Harvard Medical School, and Physician-in-Chief, Peter Bent Brigham Hospital, Boston, Mass.

Intermission

Diagnostic Clinic (Medical)
Dr. Elliott P. Joslin, Clinical Professor of Medicine, Harvard Medical School, Boston, Mass.

Diagnostic Clinic (Surgical)
Dr. Charles H. Frazier, John Rhea Barton Professor of Surgery, University of Pennsylvania School of Medicine, Philadelphia, Pa.

Diagnostic Clinic (Medical)
Dr. Harlow Brooks, Emeritus Professor of Clinical Medicine, New York University and Bellevue Hospital Medical College, New York, N. Y.

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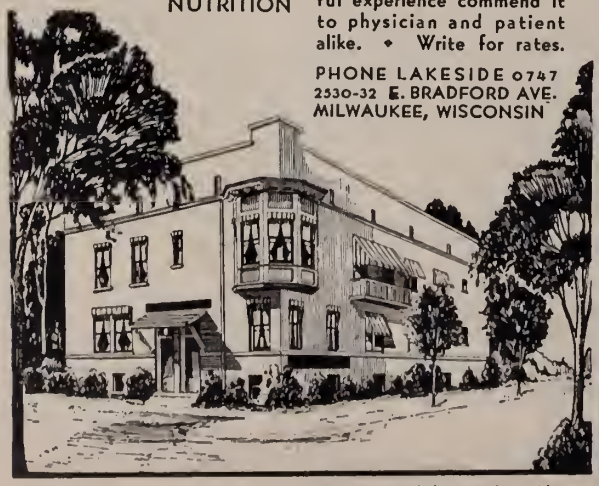

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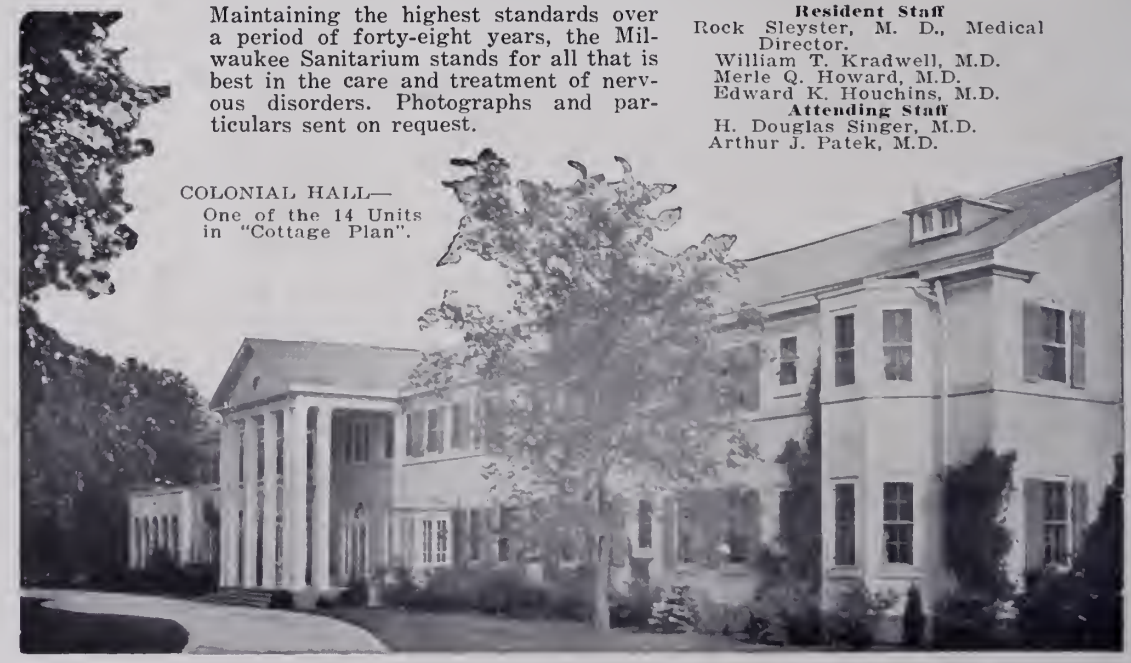

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STATE MEDICAL SOCIETY OF WISCONSIN — MEDICINA NUSQUAM NON EST

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NUMBER 11

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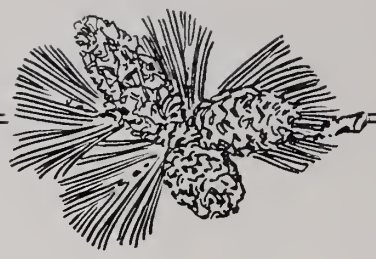

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The Wisconsin Medical Journal

Volume XXXI NOVEMBER, 1932 No. 11

The Treatment of Burns; With a Report of 278 Cases*

By STANLEY J. SEEGER, M. D.
Milwaukee

In 1927, at the annual meeting of the State Medical Society of Wisconsin, I reported a series of 83 burns from the Milwaukee Children's Hospital making special reference to the treatment of these burns by the tannic acid method as introduced by Davidson in 1925. Since that time the total number of burns treated at the Children's Hospital has increased to 278. One hundred fifty-eight of these burns have been treated by tannic acid.

All surgeons who have had extensive experience in the treatment of burns realize that no one method of treatment meets all of the requirements of every case, and that the treatment of a severe burn requires, in its various stages, a broad knowledge of surgery and a constant reorganization of therapy. A complete discussion on burns with a consideration of the etiology, prevention, clinical and pathological classifications, emergency and subsequent treatment, theories regarding toxemia and the treatment of resulting deformities is obviously impossible in the limits of a single article. Three phases of the subject will, therefore, be considered in this paper. First, the prevention of burns, second, a brief report of our experience with tannic acid at the Milwaukee Children's Hospital, and, third, research on the pH value of tannic acid solutions used in the treatment of burns.

The true importance of the problem of burns impresses itself on those who have had experience in emergency hospitals. It requires only one contact with a patient suffering from burns to strike home even to the most calloused individual the horror of these accidents. Every surgeon knows only too well that they are surpassed by no other type of accident in their ability to cause protracted and intense suffering, prolonged sepsis, disfigurement, disability and general wretchedness.

An investigation into the causes of burns admitted to the Milwaukee Children's Hospital reveals the fact that practically without exception they are due to preventable accidents. Two-thirds of the burns are due to scalding. The importance of the economic problem is emphasized by the fact that patients suffering from burns involving over 20 per cent of the body area spend, on an average, sixty days in the hospital. The disfigurement and disability often produced by these accidents need not be emphasized to medical men.

Two years ago a lay committee was organized at the Milwaukee Children's Hospital for the purpose of maintaining an educational campaign having as its object the prevention of burns in children. Methods of appeal used in the campaign have been posters, newspaper publicity, magazine articles, exhibition of educational motion pictures before groups of parents and emphasis on this subject in the homes by visiting nurses and social workers. The evaluation of results in this field is difficult, but in view of the widespread interest which has been occasioned by this work, brief mention of the statistics available will be given.

In the five years ending January, 1932, the average number of burns treated yearly was 42, or one burn to every 70 admissions. Thus far in 1932, 16 burns have been treated which will make the probable yearly total 27 with a total admission of 890 more patients than the yearly average. Had the five-year average been maintained this year, 55 burns should have been admitted or twice the number which it is estimated will be seen. While no hasty conclusions should be drawn from these statistics, it seems only fair to say that

* Presented before 90th Anniversary Meeting, State Medical Society of Wisconsin, Madison, Sept., 1931. Revised to publication date.

some definite effect can already be seen from the efforts of those engaged in the campaign. In order to retain the gains which have been made it is necessary that the work be continuous. This phase of the general subject of burns is one which should be given serious consideration in every community.

USE OF TANNIC ACID

The use of tannic acid in burns was suggested to Davidson because of its similarity to phosphotungstic acid in its property of precipitating protein. He subscribed to the theory that a specific toxin entered the circulation following a burn, this toxin being due to cleavage products of protein decomposition from burned skin. The chief proponents of this theory in recent years have been Robertson and Boyd. Davidson believed that tannic acid, by fixing the burned tissue, would prevent the absorption of this toxin to which was ascribed the secondary toxemia usually associated with burns. In short, a local chemical debridement was sought by its use. Underhill believes that the deleterious effects following burns are due to the marked increase in the concentration of blood caused by the loss of water from the organism into the burned area, and that capillary absorption is inhibited so that absorption of toxins from the burned area cannot take place. The experiments of Blalock indicate that the loss of blood plasma into the burned area may be the principal, if not the sole, cause for the shock that develops within 48 hours following burns. Regardless of which theory is accepted, the use of tannic acid in extensive burns meets the most important indications for treatment.

At the Milwaukee Children's Hospital we found the most satisfactory method of applying tannic acid to be the spray, the whole area being sprayed every 15 minutes until a firm mahogany brown membrane is formed which usually occurs within 15 or 18 hours. Our experience with this method of treating burned areas demonstrates that it has many advantages. Tannic acid as an initial dressing on a burn relieves pain almost immediately so that it is often unnecessary to administer opiates following the thorough tanning of the tissues. The precipitated protein formed provides a protective coating against chemical, bacterial and mechanical action as well as against sensory and inflammatory irritation. The general comfort and easy handling of patients is promoted, the loss of body fluids is prevented, and secondary infection, especially in superficial burns, is limited because of lack of favorable material for growth of organisms. The protective area of coagulated protein acts as a scaffold for the growth of epithelium. One of the most important functions of the skin is the mechanical protection it affords by cloaking the body in a complete mantle of dead material thus keeping the organism, to some extent, isolated from its environment. The formation of a crust or scab by tannic acid temporarily restores to the body some of the biologic functions of the destroyed skin thus allowing the organism to readjust itself to altered physiologic conditions during a period when the patient is often struggling with shock.

In deep burns as has been emphasized by Lee, and observed by me, infection may occur beneath the coagulated membrane. If any signs of sepsis appear the coagulum should be split and portions removed in order to promote drainage. Lee has made a valuable suggestion for the treatment of these deeper burns. During the tanning process he checker-boards the area by making incisions so that two-inch squares of tanned membrane are formed. This can also be accomplished by laying very narrow strips of adhesive across the burned area and tanning the squares between them.

We have observed no reduction in the mortality rate which can be ascribed to the use of tannic acid. The patients in this series were infants and children ranging in age from 2½ months to 10 years. The mortality rate for the entire series was 13 per cent. Only one per cent of those with burns involving less than 20 per cent of the body surface died. We treated 34 patients with burns involving from 20 per cent to 30 per cent of the body surface, the mortality rate in this group being 14.7 per cent. Twenty-nine patients with burns of 30 per cent or over showed a mortality rate of 94 per cent, only two of these recovering. The mortality

rate in the series treated by tannic acid and in the series treated by other methods is almost identical.

The statistics which have been published relative to the reduction of the mortality rate since the introduction of tannic acid seem to me to be unconvincing for they have been accompanied by no careful analysis of the various factors which must be considered in arriving at a fair conclusion. This series may be used to illustrate this point. In 1927 I reported 83 cases with 16 deaths, making a mortality rate of 20 per cent for this series. In the 195 cases treated since, we have had 20 deaths or about a 10 per cent mortality rate. However, 33 of the first 83 cases reported had burns involving over 20 per cent of the body surface, while only 30 of the 195 had burns of 20 per cent of the body surface.

Our records do not agree with the observations of Glover and Beekman to the effect that the mortality rate is markedly reduced after the first 24 hours by the use of tannic acid. Of the 20 patients who died and who were treated with tannic acid, four, or 20 per cent, died in the first 24 hours; none died in the second 24-hour period, and five, or 25 per cent, died from the third to the fifth day. It is during this last period that the secondary toxemia, supposedly due to a split protein toxin, should appear. Of the patients treated by other methods 56 per cent of the deaths occurred in the first 48 hours. It would seem that our experience indicates that by the use of tannic acid in extensive burns, some patients who would otherwise have died were carried through the period of initial shock but died at a later period of pneumonia, toxemia or exhaustion. The average age of the fatal cases treated by tannic acid was 2.9 years and of those treated by other methods, 3.5 years. Infants have much more skin surface in proportion to the body weight than have adults and this probably accounts for the fact that they some times die following burns involving relatively small surface areas.

RESEARCH

In spite of the fact that the tannic acid method of treating burns has been widely adopted, little attention has been given to the nature of the tanning agent other than to modify the strength of the solutions. Davidson suggested the use of a 2.5 per cent solution and various authors have suggested the use of solutions varying from 2.5 per cent to 10 per cent. All solutions advocated contain only tannic acid and water. Emphasis has been placed on the necessity for making fresh solutions immediately before use, the ordinary tannic acid powder usually dispensed being the one generally used. Lee makes the interesting statement that it has been a practice of the Jews for many years to use ink as a primary dressing on burned surfaces. He believes that the old inks made from tannic gallic acid were very efficacious because of the similarity of their action to the tanning of Davidson's methods. Our inks are now made from coal tar substances and the similarity no longer exists. He also states that a strong brew of tea makes a tannic acid solution of from about 5 per cent to 7 per cent and has used it in this manner in dispensary practice.

Inquiry made by me into the experiences of chemists working in the leather industry revealed that it was desirable for clinicians to make further investigation into the properties of tannic acid and the reaction of tissue to it. The effect of pH value of tan liquors upon the fixation of tannin by tissue proteins has been studied in the industry by Wilson and others. Variable factors affecting the diffusion of tannins into the skin, such as concentration, temperature, and kinds of tannins have also been investigated.

The pH value of human skin has been extensively studied and is discussed by Cowdry in his text on special cytology. The corneal layer has been found slightly acid, the deeper layers being near the pH of the blood. As cells near the surface die they become more acid, a phenomenon met also in other tissues. The skin, as one of the most important and interesting tissues of the body, is gradually attaining its rightful place in medicine. Its total weight is about six pounds, its area about 20 square feet, and its functions apparently more diverse than has been believed.

In order to determine the effect of pH value of tannic acid used in treating burns,

two series of experiments were conducted. In all of these experiments the animals were deeply anesthetized with ether and gave no evidence of pain. In the first series, twelve rabbits were burned with a hot iron plate, the area covered being two square inches over the right butt, time of contact being five seconds and temperature 200 to 300 C. Immediately after burning, the burned areas were sprayed with tannic acid solution. Spraying was done at intervals of about ten minutes for thirteen hours. After 24 hours, the rabbits were killed and skinned. The burned area from the right side and the corresponding area from the normal left side were prepared for microscopic study. Each rabbit was sprayed with a different solution as follows:

No.	Tannic Acid From	Per Cent Strength	pH Value
1	-------- Merck	2.5	2.92
2	-------- Merck	5.0	2.85
3	-------- Merck	10.0	2.60
4	-------- Zinsser	5.0	3.16
5	-------- Zinsser	5.0	4.00
6	-------- Zinsser	5.0	5.00
7	-------- Zinsser	5.0	6.00
8	-------- Zinsser	5.0	7.00
9	-------- Zinsser	5.0	8.00
10	-------- Zinsser	5.0	9.00
11	-------- Zinsser	5.0	10.00
12	-------- Zinsser	5.0	11.00

The first four solutions consisted of pure tannic acid and water, being the same as that advocated for clinical use up to the present time. The remaining eight were exactly like number four except for the addition of an increasing amount of sodium hydroxide to increase the pH value to the desired point.

The great degree of edema produced in the tissues by solutions in the acid ranges and the marked disruption and disorganization caused thereby are very definitely shown in the microscopic sections, a large series of which has been made. The most alkaline solution used appears to be much less harmful to the tissues than the slightly acid change from pH 7 to pH 6. It is significant that the best results were obtained at the pH value nearest 7.4. The heavy and rapid fixation of tannin and the excessive swelling of the tissues following the use of solutions in the low pH ranges would in all probability have injured viable tissue were it present. Wilson states that were these acid solutions used to tan skins in the ordinary production of leather, the skins would be ruined. In leather manufacture if the pH falls below 4 in the early stages of tanning, marked damage to the fibers occurs.

The series of experiments was repeated in 12 guinea pigs, the results confirming those relative to the effect of pH value which were observed in the rabbits.

Tannic acid has been used on the theory that it acts as a chemical fixing agent for the destroyed protein, but the evidence of possible injury to viable tissue when acid solutions are used seems to be of considerable importance. Extensive experimental work by Wilson and others indicates that the deposition of tannic acid is sufficient in pH valuses near that of the blood effectively to fix tissue which has been injured by heat without producing the edema which results when acid solutions are used. The uniformity of distribution of tannin and the rate of diffusion are undoubtedly promoted by alkalinization to a neutral or slightly alkaline point. It is conceivable that the edema which results from the use of acid solutions of tannic acid may augment the shift of fluid from the blood vessels to the tissues which, according to the theory of Underhill, occurs in burns. The studies on the action of tannic acid which have been made by chemists in the leather industry have been made on animal tissues which were not viable. For this reason one may not be able to apply them directly to clinical medicine, but it must be conceded that they are of great importance to anyone interested in the clinical use of tannic acid and indicate that sufficient attention has not been paid to the chemistry of the solutions which have been used in burns. Wilson is of the opinion that the action of tannic acid on collagenous connective tissue is probably the same in the living skin as it is in skin which has been removed from the body.

Davidson, in his paper on tannic acid, quotes Wiener as stating that the intracellular proteoses which are the supposed toxic agent in burns act only in a faintly acid medium and that their activity is entirely checked by a slight shift to the alkaline side of the neutral point. There has been clinical

application of this principle in the widespread use of sodium bicarbonate compresses and baths in the treatment of burns. Therefore, if one accepts the toxin theory of burns, it would seem undesirable to apply to the burned area an acid solution which might favor the action of the toxin.

On the basis of this experimental work we have used clinically the following solution of tannic acid:—3.975 grams of pure anhydrous sodium carbonate and 25 grams of pure tannic acid with 500 c. c. of water. This gives a solution with a pH value of 7.4. This solution has been used in several very extensive burns and in these cases gave immediate and late results which, in some respects, were superior to the 5 per cent aqueous solution of low pH value which we used formerly. The tanning occurred rapidly, the same analgesic properties were noted, and the tanned membrane which was formed was more pliable than that produced by the solutions in the low pH ranges.

CONCLUSIONS

Tannic acid solutions used clinically in the treatment of burns since Davidson's introduction of this substance are strongly acid and highly astringent, tending to cause swelling and edema of the tissues and a too rapid fixation of tannin at the surface. These disadvantages are overcome by neutralization to the same pH value as that of the blood. Apparently this neutralization is not accompanied by any loss of tanning power. The beneficial effects of tannic acid observed by clinicians are retained by the use of neutral or slightly alkaline solutions.

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Electric Burns*

By ERNEST W. MILLER, M. D.
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Personal observation has forced me to conclude that electric burns have been given consideration quite generally, as conditions wholly similar to other burns. This might well be true, so far as first and second degree burns are concerned, and for this reason I shall confine myself almost entirely to the discussion of third degree electric burns, with the exception of flash burns of the eye, which must be looked upon as something quite apart from other electric burns.

Having gone through the construction period and ten years of operation of the largest fuel producing electrical energy plant in the world, unusual hazards presented themselves but comparatively few serious burns were encountered. Several unfortunate fatalities occurred. This project afforded material which in itself was more than adequate for a comprehensive study of electric burns. I trust that my experiences over this period and prior to it, together with information from a rather constant review of the literature, may offer some points of interest to you.

* Presented before 90th Anniversary Meeting, State Medical Society of Wisconsin, Madison, Sept., 1931. Revised to publication date.

With the rapid development of electric equipment of varying character, the incident of burns may be readily assumed as an increasing hazard and a correspondingly increased problem to the physicians. Quite naturally, the most severe burns are encountered in connection with construction and operation of high voltage equipment. Nevertheless, we are at times confronted with serious situations arising from voltages as low as our electric light or household equipment circuits, namely 110 volts.

There are, doubtless, those among you who have a better knowledge and understanding of the factors which make for serious electric burns than I have myself, but, for a general review of the fundamentals, let us consider for a moment the various elements involved:

First—Direct Current.
Second—Alternating Current.
Third—Voltage, as referred to direct or alternating current.
Fourth—Amperage.
Fifth—Ohms.
Sixth—Ground.
Seventh—Length of contact.

It has been definitely established that alternating current produces more severe burns than direct current.

It is also a fact that voltage is not, per se, the greatest offender in the production of extensive or deep burns.

Amperage is quite certainly the factor of greatest damage to tissue. Then too, the resistance of the individual must enter into the picture, as also the length of time of contact, together with the character of the ground. In some cases the contact is broken by the injured person falling after becoming unconscious and in other cases the individual must be removed by force from the contact.

Given these factors, namely: voltage, amperage, resistance and duration of contact and a good ground, in proper relationship and immediately the stage is set for a catastrophe.

Next must be considered the point of entrance and exit of the current since these points determine the course of the current over or through the body.

I am satisfied, as are other students of this subject, that it is only in rare cases that the current traverses a course through the deeper structures. It seems to be quite well established that in the great majority of contacts with electrically energized equipment, the current passes over the surface of the body from the point of entrance to the point of exit or pursues a course immediately beneath the skin, following the superficial blood vessels. It has also been stated that electric current occasionally follows the greater nerve trunks; nerve trunks which might logically be conductors of electricity since they form the best distribution system within the human make-up.

The first course over the surface of the body has proven by the number of contacts in which no evidence of passing of a current is demonstrable other than the burns at the point of entrance and exit. The second course through the subcutaneous structures or blood vessels has been demonstrated in animals receiving electric current sufficient to kill, and upon skinning the animal, finding ramifying, linear burns over the entire under surface of the skin corresponding quite certainly to the superficial blood vessel distribution. The central and peripheral nervous system as a conductor has been most horribly demonstrated in a recent case under my care in which the contacts were on the occipital region of the scalp and the soles of both feet.

The patient presented a complete motor paralysis with no involvement of sensation, indicating quite conclusively that the current passed down the anterior portion of the spinal column without disturbing the posterior portion. The patient also had cerebellar disturbances, probably demonstrating the passage of the current through the posterior part of the brain. This one case shows almost every possible third degree burn and complication: Third degree burns of the scalp, necrosis of the outer table of the skull, almost complete destruction of the upper eye-lid, destruction of tendons and nerve in the right wrist, cerebellar irritation, nephritis, cataracts in both eyes and the general depletion, attendant upon injuries of such a character.

TREATMENT FOR SHOCK

Prior to consideration of the burn itself, it frequently becomes necessary to render treatment of the electric shock which has accompanied the accident. Were it not for the institution of a proper treatment of electric shock, many of our burns would require no treatment. The ignorance of many medical men of the fundamentals of such treatment has been quite astounding. Permit me, with no malice to suggest that every physician become proficient in the art of resuscitation, using the Sylvester or prone method. Such mental illumination may stand in good stead in your own immediate household or elsewhere. On various occasions, in reaching the scene of a case of electric shock, the position of the patient, together with the manner in which an attempt at artificial respiration was being made, has been nothing short of pitiable.

Third degree electric burns are so distinctive in character that even in the absence of history of contact with electric current, they should be recognized and diagnosed as such. The center of the burn has a charred appearance, immediately outside of this area is a blanched areola and surrounding this is a narrow hyperemic or reddened margin. It appears needless to discuss differential diagnosis since no other burn presents this typical picture. Third degree electric burns may be of any size from a punctuate involvement to a vast destruction of tissue, either to a minimum depth or involving all of the structures of the affected part.

FIRST AID

The first aid treatment by physician or layman, assuming that artificial respiration is either unnecessary or has been instituted and the patient resuscitated, is the free application of some protective covering with an oily base. Upon arrival at a hospital or office, if the patient's condition will warrant, immediate cleansing with tepid water and soap is effective for further sterilization and I may say that any neutral soap has as much, if not more germicidal possibilities than any of the other disinfectants generally used.

It might be assumed that the heat associated with a severe electric burn should render the surface sterile but I have in mind one patient who had an extensive burn of the foot which resulted in amputation, who was ultimately a victim of tetanus infection.

Subsequent to the initial cleansing, treatment which I have used consists of a radical excision of all necrotic or burned soft tissue. With a degree of experience the complete removal can be performed so that no healthy tissue is sacrificed and so little necrotic tissue remains, that sloughing surfaces are neglible and granulation is promoted within 24 to 48 hours. Frequently where small areas are involved, the edges of the excised wound may be sutured together immediately and healing take place by primary intention. In connection with this debridement treatment I have found it essential not only to remove all necrotic tissue but to extend the dissection beyond the red areola and excise all thrombosed veins. The arteries do not become thrombosed beyond the margin of the necrotic areas while frequently the veins may be completely occluded for some distance beyond the margin.

Since instituting this excision procedure, not only has sloughing been reduced to a minimum but edema rarely is present, absorption is neglible and other complications reduced markedly.

When I recall the months and, in some cases, more than a year of suffering and of treatment required to secure some kind of an end result in electric burns five to ten years ago, I wonder that any patient survived the salves, irrigation, Fuller's earth, paraffin, etc., which were inflicted upon them.

For the small punctate electric burns, due to contact with a single wire end or small piece of equipment, a safety razor blade is most effective in the excision of necrotic area. This may be readily undertaken with no local anaesthesia and with little, if any, discomfort to the patient.

EXTENSIVE BURNS

In all cases involving extensive excision, a plastic operation or several of them, must necessarily be instituted. With the treatment described, such measures may be undertaken in many instances in from ten days to two weeks subsequent to the injury. The

plastic operation may be of a sliding pedicle type or any of the grafting methods. The Thiersch method to me is preferable. It has quite recently been shown that a Tiersch grafted surface may ultimately be used as a sliding flap.

Cases presenting bone involvement cannot be treated by radical removal immediately. The line of demarcation in bone presents itself much more slowly and if the bone is permitted to remain intact four to six weeks, this period of time will invariably outline the destroyed areas by the presentation of a darkened bone surface. Granulations are more readily acquired under the protection of necrosing bone so that upon ultimate removal, such a surface immediately is available for further treatment.

X-ray examination of bony structures which must necessarily have been in the path of electric current shows no pathological changes immediately following the contact but at some period within four to six weeks following the contact, definite destructive changes are evident and the process described above is demonstrable.

Tendons and nerve destructions present the most serious problem since so frequently a considerable portion of either or both may be destroyed. The final treatment of nerves and tendons involved in an electric burn must necessarily be delayed for a considerable period of time and in many instances no repair is possible. It is well known that nerve suture and tendon approximation must be undertaken under most favorable circumstances in order to secure satisfactory results. It is so rare that only one tendon is involved that it is quite beyond reason to attempt transplantation of 3, 4 or 6 tendons for the minor degree of improvement which may be expected in function.

Flash burns of the eye, referred to earlier in this paper, cannot be considered as real burns since there is, in the majority of cases, no destruction of the tissue. Almost without exception, no immediate symptoms present themselves. It requires a period of from four to eight hours for the effects of the irritation of the flash to make itself known to the patient or visible to the physician. This fact must be borne well in mind in order to avoid the ultimate, severe irritation which arises in all untreated flash burns. Immediate treatment with some germicide, preferably in oily solution, will, in practically all cases, wholly eliminate the irritation which arises in untreated cases. Such treatment, not only affords great relief to the patient, but in many instances, is a source of great convenience to the attending physician by obviating necessity of treatment during night hours.

It is impossible in a brief space of time to cover the subject of electric burns. Each factor involved might well be made a separate study. I have, however, attempted to review only the high lights as they have been brought forcibly to my attention.

If this presentation has aroused a little interest on the part of some of you in a field of ever growing importance to us, individually and collectively, I shall have accomplished, in part, my aim in presenting the subject. It is to be hoped that from a scientific point of view you will interest yourself in a treatment of electric burns which may accomplish shorter periods of disability, a lesser degree of suffering, and an ultimate reduction of radical deformity.

HEARING BEFORE REGENTS

Presentation of the findings and recommendations of the State Medical Society of Wisconsin with reference to the admission of various types of patients to the Wisconsin General Hospital was made before a meeting of the Regents of the University of Wisconsin at Madison on October 15th. Members of the committee present at this hearing included Drs. S. E. Gavin, Fond du Lac; F. W. Pope, Racine, F. Gregory Connell, Oshkosh; John L. Yates, Milwaukee; Joseph Dean, Madison, and President Reginald H. Jackson, Madison. The presentation was made by Mr. J. G. Crownhart, Secretary of the State Society.

At the conclusion of the hearing, President Fred Clausen of the Regents appointed a special committee of the Regents consisting of George W. Mead, Wisconsin Rapids, Chairman; Harold M. Wilkie, Madison; John Callahan, Madison; Dr. Gunnar Gundersen, La Crosse; Mrs. Meta Berger, Milwaukee, and President Clausen, ex-officio. This committee will make a further study and report its recommendations to a future meeting of the Regents.

Parenterally Administered Liver Extract in Pernicious Anemia*

By WILLIAM S. MIDDLETON
Madison

To the already weighty evidence for the efficacy of liver extract parenterally administered in pernicious anemia, ([1, 2, 3, 4, 5, 6, 7, 8]) further support is offered in a series of 20 patients so treated in the State of Wisconsin General Hospital. Death occurred in 2 of these individuals from intercurrent infections and in 2 others the response to the therapy was not deemed adequate. The remaining sixteen experienced complete blood remissions from liver given intravenously, intramuscularly, or subcutaneously.

In figure I the response of a typical case of pernicious anemia to the intravenous administrations of liver extract is obviously prompt and adequate. Higher reticulocyte responses have been observed, but, in general, this case is characteristic for the group. For a comparison of the erythropoietic reaction to liver administered by the oral and by the parenteral routes the curves in figure II were plotted. This patient on an earlier admission (response plotted in curves IIA and IIB) had received liver extract in large doses (material derived from 1500 grams of liver daily) orally for the first 3 days and thereafter average doses (the equivalent of 300 grams of liver daily) for the period noted on the curve. On the second admission liver extracts for parenteral use were available and he received doses of the same equivalent to 100 grams of liver intramuscularly daily for 3 days and the same dosage thereafter every 5 days. The response is charted in curves IA and IB of figure II. Unfortunately for the sake of scientific accuracy a short period of irregular liver therapy by the oral route had preceded the second admittance. This circumstance accounts for the high initial level of reticulocytes; but the later rise of these elements to 22.8 per cent in response to the intramuscular therapy may be cited as evidence of the inadequacy of the oral medication.[9] Attention is also directed to the singular coincidence of the curves of response, IA and IIA, IB and IIB, a circumstance which bears out an earlier contention that the erythropoietic response to the optimal dose of a potent ex-

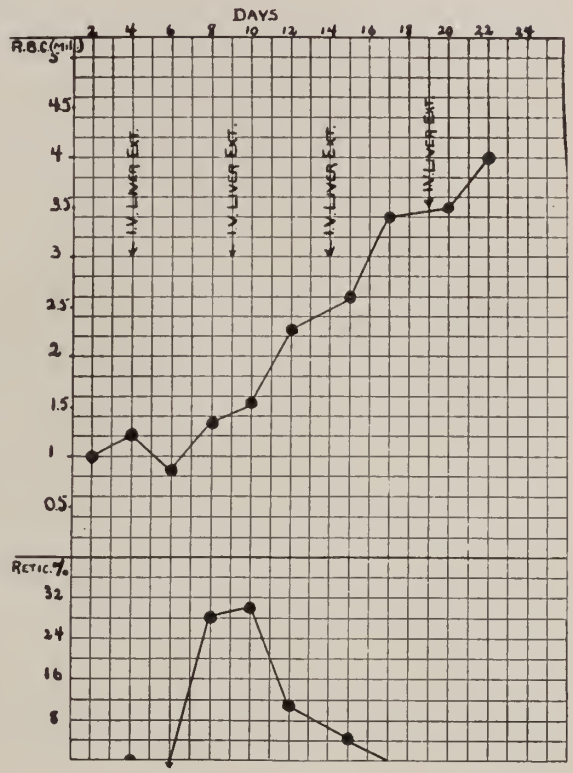

Fig. I.

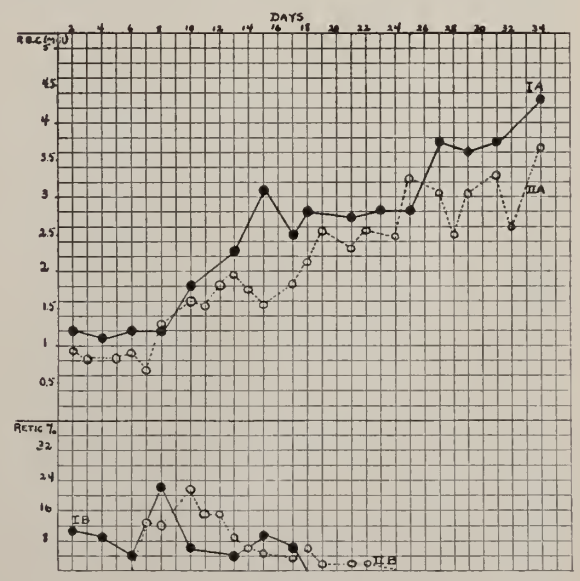

Fig. II.

* From the Department of Medicine, University of Wisconsin.

tract is maximal in a given individual with pernicious anemia, regardless of the number of relapses.[10] This experience has been repeated a number of times where the opportunity to study recurrent relapses in patients with pernicious anemia has presented itself.

As in any other new preparation and new route of administration, close observation has been made for adverse reactions. The results have been quite interesting and fortunately apply only to the patients receiving intravenous injections of the several liver extracts. Chills occurred in three individuals a total of four times. The time factor in the administration of the extract was an important one. The larger doses of twenty cubic centimeters were given in 15 minutes as a routine. The patient who suffered a frank rigor on two occasions under this routine escaped an adverse reaction when 20 minutes were taken to complete the intravenous injection. This experience emphasizes the necessity for individualization in this as in all therapy. Transient dizziness and a sense of uneasiness were remarked by three patients during the injection. An evanescent flushing of the face was noted on several occasions.

The most important objective observations related to the blood pressure reactions to the intravenous injection of liver extract. Determinations of the blood pressure were made at frequent intervals during and succeeding these injections on 53 occasions in 12 patients. Invariably a fall occurred in the systolic pressure. The time and the degree of this fall varied in the same patient on different occasions; so that these factors could not be predicted in subsequent injections. Nor did the initial level of systolic pressure bear any relation to these details. Forty-eight millimeters (Hg.) was the greatest fall in the systolic pressure and 6 the least. Diastolic pressures varied somewhat more than the systolic readings in the individual case. In a single instance a rise of 4 millimeters was noted and no change occurred in the diastolic pressure during two other intravenous injections. The rule, however, was for a decline in the diastolic pressure as well as the systolic and a maximum fall of 42 millimeters was noted in this element. Interestingly 10 observations of the 53 showed a return of the blood pressure to the pre-injection level before the conclusion of the injection of the liver extract. As implied above, no similar changes were established when the subcutaneous and intramuscular routes were utilized.

DOSAGE

The standardization of dosage offered many problems depending upon the change of potency of the extracts and especially upon the change in their route of administration. It soon became apparent that the efficacy of a given preparation was greatly enhanced upon parenteral administration. Apparently dependent then upon the uncertainty and incompleteness of absorption, the oral route proved most wasteful. The efficacy of an extract derived from an equivalent weight of liver was many times greater when administered parenterally than orally.

Granting the prompt and adequate response to parenterally administered liver extracts as indicated in figures I and II, the next question arose as to maintenance dosage. Figure III indicates the common experience when the plateau of erythropoietic response was used as a guide to the necessity for further therapy. It will be remarked that a lag occurred in the response to successive doses of liver extract. The peak of response to the first dose was reached on the twentieth day. When the erythrocytic counts on the twenty-second and twenty-third days showed a slight slump, the second dose of liver extract was given intravenously. A lag of 6 days elapsed before the definite response was recorded on the twenty-ninth day. A slight but less marked inertia followed the third dose. This experience was repeated a number of times before it was capitalized into a routine which has proved most satisfactory.

As a matter of economy of time and substance a constant dosage of the extract under trial, namely that amount derived from 100 grams of liver, has been administered parenterally every 5 days. The arbitrary amount and time interval further afford standards of comparison. Extended experience may prove that both factors can be altered to ad-

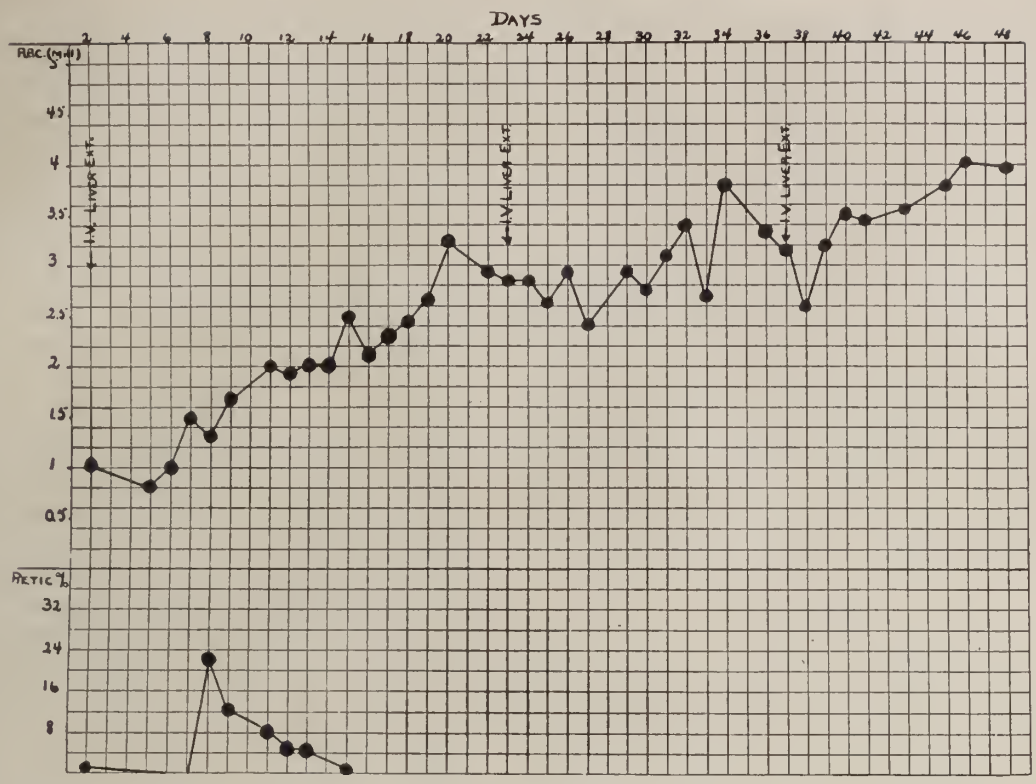

Fig. III.

vantage. The described reactions* and the increased hazard of the technique distinctly limit the usefulness of the intravenous route, so that the intramuscular method is now preferred. Further trial may favor the subcutaneous route, but at present the necessity for smaller and more frequent injections reduces the utility of the last named method. As a rule the patient has been maintained on the above regimen for a period sufficient to bring his erythrocyte count to 4 millions. Thereafter by trial and error the frequency of injections is reduced to that number and interval necessary to maintain a level of 4.5 to 5 million erythrocytes. Usually this has meant an intramuscular injection of the equivalent of 100 grams of liver in an extract every 2 or 3 weeks.

The early students of this phase of the subject insisted upon the availability of liver extracts for parenteral use only as a substitute for the oral preparations in dire necessity or when some circumstance precluded the ingestion of liver or its equivalent. Conner[8] especially stressed this point and Professor John H. Musser in discussing Conner's excellent resumé of the subject cited an apparently conflicting situation in the acceptance of the various liver extracts for parenteral administration to the exclusion of the established effective agents for oral use at a time when every effort is being bent toward the development of a potent insulin for administration by mouth in diabetes mellitus. The cases are by no means analogous and with the exception of Murphy[5] all cited authorities have missed one of the most important factors, namely the cost of treatment. In this circumstance alone is the therapeutic problem of diabetes mellitus akin to that of pernicious anemia. In both conditions the economic phase of costly medication is militating against the assured success of its regular application. Here the parallelism ceases. The need for a technical method of administration (by injection) is daily, or repeated within the 24 hours, in the

* Footnote: Wilkinson[11] has produced a potent liver extract for parenteral use which may be given intravenously without depression of the blood pressure. Several American pharmaceutical houses have claimed similar advantage in their recent products.

case of insulin, whereas after the period of stabilization the pernicious anemia patient requires parenteral injections at intervals of from 2 to 3 weeks. This circumstance will insure the continuance of a physician's attendance in pernicious anemia. Then, too, the laboratory methods governing the maintenance therapy in the two conditions are quite different. While a diabetic patient may be safely intrusted with the hypodermic administration of the potent insulin after the proper instruction in the dietetic limitations and in the significance of glycosuria, the laboratory methods for the control of liver therapy are too complicated to warrant any thought of applying them in the same relation to the patient with pernicious anemia.

LIVER EXTRACT

If all factors were equal, the oral route would, of course, take precedence; but the apparent extravagance of this method renders it less desirable for the time being at least. Calves' liver costs 60 to 80 cents a pound, although less palatable sources of liver may be procured for as little as 30 cents a pound. Dismissing for the time being the initial dosage necessary to effect a blood remission, it may be granted that the average patient with pernicious anemia will require 250 grams of whole liver daily for the maintenance of this advantage. At the quoted market price, whole liver for a month (30 days) would cost from $4.50 to $12. Few patients can tolerate hog's liver for long periods; so that it is fair to conclude the cost, based on the prices quoted for calves' liver, as $9 to $12. The various liver extracts rated on the basis of material obtained from 100 grams of whole liver range in retail price from 14 to 27 cents. Accordingly the cost of a month's medication in the ordinary daily dosage of the extract derived from 300 grams of liver would vary between $12.60 and $24.30. With the extracts for parenteral use varying from $1.33 to $4 for the material derived from 100 grams of liver, the maintenance cost of this form of treatment can be estimated at $1.88 to $8 per month, depending upon the basic price and the interval.

The difference in the cost of materials of equivalent potency for the several routes of administration is quite apparent and the very low cost of parenteral therapy constitutes a strong argument for its utilization, if all other circumstances be equal. The hypothetical loss of certain important elements required for the neurologic remissions through the extraction of whole liver[12] has not found wide acceptance. Until such a circumstance is established, no fundamental objection to the parenteral administration of liver extract at such long intervals as are necessary for the maintenance of the blood remission in pernicious anemia, can be seriously entertained. Where such a wide discrepancy exists between the potency of the equivalent liver product orally and parenterally administered, either a fundamental and unalterable factor of absorbability must be admitted as limiting the field of usefulness of the oral route or every effort must be extended to enhance its efficiency. Certain it is that, unless the cost for the orally administered products be radically reduced, the parenteral route will pratically supersede the oral in the application of liver therapy. From the economic standpoint this position is further strengthened by the abbreviation of the period of invalidism and of hospitalization.

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Transurethral Resection of the Prostate; A Conservative Procedure for the Relief of Prostatic Obstruction*

By GEORGE H. EWELL, M. D.
Madison

Many discussions of this subject have appeared recently. Undoubtedly the subject of the treatment of prostatic hypertrophy is an important one, and the development of a conservative procedure for the relief of prostatic obstruction will command the attention of the general practitioner as well as the urologist. I wish to discuss this morning the general aspects of the subject as my experience has been limited to less than fifty cases. I will not present statistics as they would prove little either way, nor do I wish my conclusions to appear dogmatic.

In 1844 Mercier introduced his prostatome for transurethral incision of an obstructing prostate; hemorrhage was a serious complication. In 1873 Bottini introduced his galvenocautery incisor; this instrument failed to control hemorrhage and sepsis commonly occurred following its use. In 1909 Young introduced his punch, an instrument that would actually remove tissue. It was designed to treat principally that group of cases called prostatic bars and vesical neck contracture. In 1920 Caulk introduced his cautery punch and since that time has repeatedly insisted that the punch operation had a wider field of application than that generally accepted by most urologists, maintaining that a great portion of the obstruction from an enlarged prostate was due to edema and that by removing the obstructing portion of the prostate congestion was relieved and marked shrinkage of the gland occurred. All surgeons have noted this change following the introduction of a suprapubic tube and noting the greatly reduced size of the gland when prostatectomy was done at a later date. Engel recently confirmed Caulk's views when he noted relief in his patients where the commissural hypertrophy was resected and very little attention paid to the lateral lobes.

Since 1920, many new instruments have been devised and the various types of electrical currents used in conjunction in an attempt to correct prostatic obstruction. In 1926 Stern introduced a new idea, that of prostatic resection through an instrument called the resectoscope. The method was not popular and urologists did not recognize its possibilities due undoubtedly to imperfections in the instrument. In recent years Davis has modified the Stern instrument and has reported a series of two hundred cases with excellent results that even the most skeptical cannot deny. McCarthy has adapted a loop electrode to use through his panendoscope, both men employing the radio knife current to slice away the obstructing portions of the gland and further controlling hemorrhage by coagulating the bleeding points with the coagulating current. With the development of these instruments the treatment of prostatic obstruction now assumes a different aspect, and the prostate, as McCarthy states, "now stands at the crossroads."

The selection of cases suitable for this procedure depends on the operator's armamentarium, careful and complete urological examinations. For that class of cases designated as poor surgical risks this method offers a definite hope. Preoperative preparation is just as essential as for prostatectomy, such as decompression of an overdistended bladder, appropriate measures for the care of an existing cystitis and upper urin-

* Presented before Methodist Hospital Post-Graduate Clinic, Madison, March 22, 1932.

ary tract infection, copious fluid intake to promote kidney secretion and the decrease of nitrogen retention. It may be necessary to employ suprapubic drainage by means of a trocar and cannula; however, in the experience of most men this procedure is becoming more and more unnecessary. For anesthesia I employ intradural caudal, a method developed by myself, for all types of operative cystoscopic procedures. The patient experiences no pain and the average anesthesia lasts from one to two hours or more, thus allowing ample time for the removal of as much or as little tissue as deemed advisable and to control all bleeding points, which reduces to a minimum this formerly dreaded complication. Following the operation an indwelling catheter is inserted for two to four days and for the first twenty-four hours is carefully irrigated every half to one hour to prevent clogging and the production of bladder spasm. After its removal the patient is advised to remain quiet for several days.

The use of a suspensory to guard against epididymitis should be employed during the preparatory and postoperative periods, or vasectomy may be done. In all the articles on the subject, it is remarkable to note how little reaction follows the procedure and recovery is quite rapid. The average hospital stay is ten to fourteen days as compared to about six weeks for prostatectomy. The permanency of relief appears to compare favorably to that of prostatectomy. In case of failure to control symptoms or to relieve obstruction the operation can always be repeated.

It is an ideal method for the relief of obstruction in carcinomatous hypertrophy. In some clinics the method is being employed in over ninety per cent of the cases of prostatic obstruction. It may be offered as a prophylactic measure in early cases of prostatic enlargement to forestall, if possible, the more serious sequelae of prostatic obstruction.

CONCLUSION

I feel sure that transurethral prostatic resection is here to stay and that the future will offer much in improvements. As yet the limits of the procedure are not defined.

Syphilis; An Appraisal of Additions to the Treatment of Syphilis During the Last Decade*

By MAURICE J. REUTER, M. D.
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Since the introduction of arsphenamine and its derivatives in the treatment of syphilis, there is no question but that the results are more satisfactory than those ever previously obtained. However, since new remedies are constantly being introduced, it is evident that arsphenamine alone does not take care of all the situations arising in the control of a syphilitic infection. Nevertheless, arsphenamine is still supreme as a spirocheticide and is the most rapid agent for the sterilization of the syphilitic organism. In as much as it is impossible to discuss, in a short time, all the agents introduced for the treatment of syphilis during the past decade, I shall confine myself to those which have proved most valuable, namely: bismuth, bismarsen, sulpharsphenamine, tryparsamide, malaria, and typhoid vaccine.

In attempting to state my opinion briefly, I shall undoubtedly appear dogmatic where there is certainly room for broad differences of opinion.

BISMUTH

About 10 years have elapsed since bismuth salts were introduced in the treatment of syphilis. The first reports on the use of this drug were by Sazerac and Levaditi in 1922. As time is the only dependable measure of the worth of a remedial agent, many more years will elapse before we can properly evaluate bismuth preparations.

Because of the number of bismuth preparations on the market, each said to have some special value, we are somewhat at a loss in choosing a suitable one. At the present

* Presented before the Wisconsin Urological Society.

time, it is impossible to state just what is the best bismuth preparation to use, and how much bismuth it is necessary to give. Greenbaum and Rule have shown that the curative value of bismuth compounds does not depend on the amount of bismuth in the compound nor upon the total amount of bismuth injected. It has been suggested that it is not the total amount of bismuth metal given that is active therapeutically, but more probably the ionizable bismuth. Regarding the choice of a bismuth preparation, Cole, Moore, O'Leary, Stokes, et al, state that at present we can stand on our insoluble suspensions in oil of the potassium bismuth tartrate and of the tartro-quiniobine and of the salicylates and subsalicylates. They also state that a suitable bismuth preparation should probably contain from .03 to .2 grams of metallic bismuth to the dose and that a course of bismuth therapy should last from 8 to 10 weeks and in this period, a total of from .6 to 2 grams of metallic bismuth be given.

The bismuth preparation with which I am most familiar is potassium bismuth tartrate in oil suspension. This preparation is given intramuscularly, .1 to .2 grams to the dose every 3 to 7 days. I prefer .1 gram simply because it is much easier to aspirate into a syringe and there is little waste as compared to the .2 gram ampule. If well tolerated, 10 to 20 doses are given to a course.

Bismuth has been definitely proved to be a spirocheticide causing the spirochetes to disappear from the chancre or mucous patch within 4 to 5 days or longer. It is, however, decidedly slower in action than arsphenamine which will cause the disappearance of spirochetes from contagious lesions usually within 24 to 48 hours. The action of bismuth on the chancre and enlarged glands and on the secondary eruption is likewise much slower than arsphenamine. At present, in view of the proved value of arsphenamine, we are hardly justified in employing bismuth alone in the treatment of early syphilis. The combined use of the two drugs, however, is a desirable procedure. If, in acute syphilis, a contraindication to arsphenamine exists, one of the water-soluble bismuth preparations which are rapidly absorbed, could well be employed. Bismuth does not produce a Herxheimer reaction and the blood Wassermann is not reversed as rapidly as with arsphenamine. There is no question but that bismuth has a favorable influence on neurosyphilis and can be used as an adjunction to treatment with arsenicals or other remedies. It is of great value in the treatment of congenital syphilis, and, with the dosage modified according to age, is very well tolerated by infants and children. Besides furnishing us with another mode of attack in the control of Wassermann-fast and relapsing syphilitic infections, it is a valuable remedy both in cardiovascular syphilis where arsphenamine is contraindicated and in visceral syphilis.

When given intravenously, bismuth is ten times as toxic as when given intramuscularly and therefore this route of administration is hazardous. Given intramuscularly, bismuth produces few complications. The commonest ones are the blue line on the gums, and stomatitis which can be avoided if the mouth is kept clean and infected teeth and pyorrhea pockets cleaned up. Albuminuria, a "bismuth grippe", and local abscesses occasionally occur and dermatitis has been described, but is uncommon.

To sum up, in the treatment of syphilis, bismuth is a valuable remedy which is to be used as an alternate with, or a substitute for, mercury. At present, it should not be used alone nor as a substitute for arsphenamine except perhaps in cardiovascular syphilis, latent syphilis, and in the so-called Wassermann-fast cases of syphilis who have had a reasonable amount of treatment with the arsenicals.

BISMARSEN

(Bismuth Arsphenamine Sulphonate)

Bismarsen represents the successful culmination of a long series of chemo-therapeutic attempts to combine two well known spirocheticidal agents namely arsphenamine and bismuth in a single compound. The drug was synthesized by Dr. G. W. Raiziss in 1925. The first clinical report on the use of the drug was made by Stokes in 1927.

Bismarsen is supplied in two ampules. One ampule contains .2 grams of yellow, powdered bismarsen, while the other con-

tains 2 cc. of butyn water in which the powder is dissolved. The arsenic content varies from 13–15% and that of bismuth from 23–25%. It is given intramuscularly .2 grams at intervals of four to seven days until a total of 10 to 20 injections have been made. After a rest period of 2 to 4 weeks, there is given a second course of the 10 to 20 doses followed by another rest period and the customary third course of bismarsen. Four to five courses are often given in acute syphilis, and Stokes recommends as many as forty injections before a rest period.

Because bismarsen is given intramuscularly, it possess these advantages over arsphenamine: greater ease of injection and simplification of treatment, especially in the case of children and obese adults; greater freedom from possible toxic reactions, and in addition, lower cost.

Intramuscular injections are more slowly absorbed and more slowly eliminated, and therefore afford more time and opportunity for therapeutic agents to reach and penetrate infected syphilitic tissues and the spirocheta pallida itself.

The toxicity of bismarsen is very low, although it does occasionally produce some constitutional reaction, such as generalized pruritus, dermatitis, arsenical neuritis, hepatitis and occasionally stomatitis. Sometimes nodules are formed in the buttocks. While admitting the advantages of bismarsen, it is the question of therapeutic effects that is of primary importance. The spirocheticidal action of bismarsen is much slower than the arsphenamines. The spirochetes do not disappear from an infectious lesion, such as a chancre, until three to five days after an injection and the healing of the lesions takes place more slowly. The early reports on the use of bismarsen in acute syphilis were very encouraging. The majority of the authors reported a low incidence of relapse and reactions, although the acute signs of syphilis disappeared more slowly than with other preparations of arsphenamine. Stokes in his most recent articles on the treatment of syphilis with bismarsen is very enthusiastic about the use of this drug in early syphilis. O'Leary and Brunsting, in checking up a number of early cases of syphilis presumably adequately treated with this drug, were unable to confirm the work of previous men; in fact they discovered that the incidence of relapse, chiefly through finding a positive Wassermann in the spinal fluid, was much greater with this drug than with the use of arsphenamine. Since the percentage of relapse was about 30%, it is evident that birmarsen has no place in the treatment of acute syphilis, except, perhaps, in patients well past middle life. It has, however, a definite place in the treatment of chronic syphilis such as in middle aged patients with no other signs of syphilis other than a positive Wassermann; in cardiovascular syphilis where intravenous medication with the arsphenamines is contra-indicated; in the treatment of the so-called "Wassermann-fast" cases of syphilis and in certain types of neurosyphilis. Finally, its greatest value lies in the treatment of congenital syphilis, because it permits inter-muscular medication in infants among whom intravenous therapy with arsphenamine is ordinarily difficult.

SULPHARSPHENAMINE

This drug is chemically similar to neoarsphenamine, but is usually given intramuscularly. For this reason, it is especially advantageous in the treatment of children. It causes little or no discomfort; it is rapidly absorbed and eliminated and apparently has a penetrating power for the nervous system of a greater degree than any other spirillicidal drug. .3–.4 grams are usually given at weekly intervals. The drug is effective therapeutically, but has many disadvantages due to its toxic nature. Dermatitis and peripheral neuritis occur in a much greater percentage of cases than with other arsphenamines. In addition, it seems to have a selective action on the hematopoietic system, causing aplastic anemia and purpura hemorrhagica. Because of these factors, I have discontinued its use. At the present time, in cases where it was especially indicated such as infant congenital syphilis, I have replaced it with bismarsen.

TRYPARSAMIDE

Tryparsamide, after a carefully controlled clinical trial, was placed on the open market in 1925. It is a pentavalent arsenical com-

pound in the form of a white crystalline powder, readily soluble in cold, distilled water. It is administered intravenously. The adult dose is 1–3 grams which should be repeated at weekly intervals, until, to complete a course, 10–15 injections have been given, following which there is a rest period of a month or two before repeating the course. Tryparsamide has no value in the early stages of syphilis and is of little value in latent syphilis or tertiary lesions and is unsuitable for use in early neurosyphilis. The use of tryparsamide should be confined to late neurosyphilis. It has been most successfully used in general paresis, but, good results have also been reported in meningo-vascular syphilis, tabo-paresis and tabes.

The contemporary concensus of opinion is that in early paresis, malaria is the treatment of choice. Also in meningo-vascular syphilis, early tabo-paresis and tabes dorsalis, treatment with arsphenamine, bismuth, or mercury and iodides far overshadow the benefits to be derived from tryparsamide.

Despite all this, tryparsamide has a definite place in our scheme of treatment. It is particularly useful in patients with paresis in whom malaria is contraindicated and in paretics who have not responded to malaria. Tryparsamide also might be used in patients with other types of neurosyphilis, who, because of hypersensitiveness, cannot tolerate arsphenamine or are resistant to the ordinary measures. However, in these cases, as I shall emphasize later, malaria is the treatment of choice.

In order to obtain clinical improvement with tryparsamide, it must be given over a long interval and from fifty to one hundred or more injections are often necessary. It is well to explain this to the patients or their relatives before undertaking treatment. Tryparsamide has a toxic action on the optic nerve and may produce blindness in persons who have early symptoms or signs of optic atrophy. Therefore, before undertaking treatment, an examination of the eye grounds and visual fields should be done. In the presence of any impairment of the optic nerve, the drug should be withheld. Subjective disturbances of vision in patients being treated with the drug, for instance the complaint of seeing flashes of light, are danger signals and call for immediate cessation of treatment.

FEVER THERAPY IN NEUROSYPHILIS

Since 1887, it has been known that intercurrent febrile disease had a beneficial effect in general paresis. Working on the assumption that the beneficial results observed were due to the hyperpyrexia, many methods of producing fever have been introduced. Some of the methods employed have been: infection with the spirochetes of relapsing fever, injections of neuclean and tuberculin, inoculation of patients with malaria, the injection of combined typhoid vaccine, and most recently the production of fever by means of diathermy. The only methods with which I have a working acquaintance are those of the production of fever by means of infection by the malaria parasite and by injections of combined typhoid vaccine.

MALARIA

Experimenting with the treatment of paresis by means of fever, Wagner von Jauregg, in 1917 came to the conclusion that the actual presence of an infectious disease was required for the best therapeutic results. Therefore, in the same year, he systematically undertook the inoculation of paretic patients with tertian malaria. His first comprehensive report was published in 1922. Goeckermann is of the opinion, shared by a host of syphilographers, that malarial therapy is one of the outstanding achievements of modern therapeutics.

While the treatment is not complicated, the mortality rate varies from 6–10%. The risk incurred, however, is justifiable in view of the nature of the malady being treated. The malaria therapy is instituted by inoculating intravenously or intramuscularly blood obtained from a patient in the active stage of infection. It is possible to transport the malaria infected blood; so the problem of availability is not too serious.

In order to transport the blood, it is drawn off from the infected patient into a test tube containing sodium citrate to prevent clotting. The test tube, well protected with cotton, is then placed into a thermos bottle. In this

way the blood can be kept reasonably warm and is easily transported. Infections have been obtained from blood 24–48 hours old and after being carried half way across the continent. Inasmuch as only tertian malaria runs a fairly benign course and responds readily to quinine, it should be the only strain employed. Following the inoculation with the malaria infected blood, from 3 to 10 days elapse before the patient comes down with clinical symptoms of the disease. As a rule 10 to 12 paroxysms are permitted before the malaria is checked with quinine. The paroxysms occur at regular intervals of about 48 hours. The temperature during the height of the paroxysm usually ranges from 104–106° F., but the height of the fever apparently does not influence the therapeutic result.

Cachexia, anemia, albuminuria, edema of the ankles, icterus and enlarged spleen and liver are often noticed during the febrile course. The heart must be closely watched and it is advisable to take frequent determinations of the blood urea, for it furnishes a reliable index of the patient's condition. After the required number of paroxysms, the fever is readily stopped with quinine which is continued at intervals for a month.

In about 40% of the cases of paresis, there is a satisfactory remission to the extent that these patients are able to return to their normal mode of life. Treatment by malaria is of the greatest value in paresis sine paresii and early paresis without symptoms. Malarial therapy, however, is also of great benefit in other early types of syphilis of the central nervous system which are resistant to the ordinary measures. In this connection O'Leary emphasizes especially asymptomatic neurosyphilis, which is manifested solely by the presence of a strongly positive spinal fluid; the patients do not give clinical signs of involvement of the nervous system. It is seen in all phases of syphilis and is particularly significant because it frequently is the basis for the development, years later, of parenchymatous neurosyphilis, such as paresis. The use of malaria in these early cases which are resistant to ordinary therapy is a distinct step in advance in the prevention of dementia paralytica or other late serious types of involvement of the nervous system due to syphilis.

Malarial therapy is of little value in paretics who have had their symptoms for a long time primarily because of the extensive damage already done to the parenchymatous nervous tissue by their syphilis. On the whole, it is of limited value in frank tabes dorsalis with lightning pains and gastric crises, syphilitic optic atrophy, or juvenile paresis. As a general working rule, late parenchymatous neurosyphilis is not benefited by malaria. However, Wile recently reported surprisingly excellent results in the treatment of various types of late neurosyphilis with malaria. Regarding the action of malaria, Barr and Breutsch, from post mortem examination of patients with paresis who had been treated with malaria, have presented evidence to show that the benefits derived are possibly the result of the stimulation of the cells of the reticulo-endothelial system, and that the plasma cells of the syphilitic infiltrate probably immigrate into the brain vessels taking part in the phagocytosis of the young plasmodia. Thus the perivascular infiltrations disappear and normal conditions are re-established resulting in a recovery of the ectodermal tissue (ganglion and glia cells). Paradoxically, seen especially in paresis, there may be no change in the spinal fluid although the patient has had a complete remission of symptoms. However, after months or years, the spinal fluid may return to normal. The neurologic picture, of course, remains unchanged. In other types of neurosyphilis, the spinal fluid tends to return slowly to normal. Because malaria exerts little if any benefit other than in syphilis of the nervous system, it is customary to begin the use of anti-syphilitic remedies in six months to a year following a course of malaria. However, this statement might be challenged since Denny and his co-workers have recently shown that malaria, when given to the syphilitic human organism has apparently a definite anti-syphilitic action no matter where the process is located. They report benefit from malaria therapy in interstitial keratitis, syphilitic hyperplastic bone disease, joint disease, and malignant skin syphilis.

MALARIAL TREATMENT OF ASYMPTOMATIC NEUROSYPHILIS

Mrs. R. W., age 33, acquired syphilis in 1924. From 1924-1930 she received about 50 neosalvarsan and 100 intramuscular mercury and bismuth injections. The blood Wassermann test was always 4 plus. She came under my care in October, 1930. A diagnosis of asymptomatic neurosyphilis was made.

Date	Blood Wassermann	Cerebrospinal Fluid				Treatment
		Wassermann	Ross Jones Noguchi	cells per c. mm.	colloidal gold	
10-1-30	4 plus	4 plus	positive	50	2334431 000	6 arsphenamine .3 and 4. gm. 30 Hg succinimide. 6 Bismuth
4-1-31	--------	4 plus	positive	26	2333210 000	malaria
9-1-31	neg.	neg.	faintly positive	9	0122100 000	none

TYPHOID VACCINE

The method of producing fever by means of injections of combined typhoid vaccine in neurosyphilis is rather an old method. However, in the past five years, the method has again come into vogue and there have been a number of reports in the literature. Injections of the vaccine are given intravenously at 2 to 3 day intervals. The first dose is of a size calculated to cause a definite fever, usually 5–10 million dead bacteria. The dosage is raised with each successive injection, the amount depending on the height of the fever brought about by the previous injection. As a rule, 15 to 20 injections are given to a course which may be repeated at four months intervals.

While good results have been obtained in dementia paralytica and other types of resistant neurosyphilis, the therapeutic effectiveness of typhoid vaccine is distinctly lower than that of malaria. This may be due to the fact that the fever obtained with typhoid vaccine is lower than that attained with malaria, where, as a rule, the fever is over 104°F. with peaks of 105° and 106°. However, this point is debatable especially since it certainly is not proved that the benefits derived from malaria are the results of the fever. The chief advantage of injection of typhoid vaccine is the convenience and comparative safety with which this treatment can be given.

The method can be carried out in those cases of paresis or resistant neurosyphilis where malaria is contra-indicated because of an extreme risk to life and in those cases where immunity to malaria apparently exists. It can also be given to those paretic patients who have not responded to malaria although here injections of tryparsamide would seem to be the method of choice.

The objection that in the treatment with typhoid vaccine the fever obtained is much lower than that of malaria has recently been overcome by Nelson who suggested that a second dose of vaccine be given during the height of the fever produced by the first injection. This second dose seems to have the effect of exploding the charge supplied by the first. In this way, relatively small doses are capable of producing fevers from 105°–107° F. This method appears susceptible of further development.

While good results have been obtained by means of treatment with typhoid vaccine, its therapeutic effectiveness is so much lower than that of malaria that it should be used only as a second choice.

Finally, as O'Leary has stated, the ideal indication for fever treatment, especially malaria, is found in the patient with asymptomatic neurosyphilis who has had intensive courses of intravenous and intramuscular therapy, but in whom the spinal fluid remains positive and the colloidal benzoin or gold curve continues to be of the paretic type.

CONCLUSION

The past decade has yielded noteworthy additions to the armamentaruim of syphilis therapy, especially neurosyphilis. However,

in this ever-changing world, remedies and methods of today may be obsolete twenty or even ten years from now. Nevertheless, we must accept with extreme caution new remedies offered by the various manufacturers for the treatment of syphilis and wait until their worth is unquestionably proved before adopting them.

Glimpses of Pioneer Wisconsin Health Work

By HOYT E. DEARHOLT, M. D.
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While Wisconsin was the 30th territory admitted to statehood, it was the 10th state to establish a State Board of Health. This was in 1876, seven years after Massachusetts organized the first such board in 1869.

This rapid development of State Health Departments in the years following the Civil War naturally makes one wonder whether it was a sudden up-welling of public interest in disease prevention, or whether some of these states merely followed a new fashion in state commissions. Going through the early reports of Wisconsin's first State Board of Health, however, there is no sign of a perfunctory following of fashion. Indeed, the seriousness and enthusiasm with which the first seven members entered upon their duties is inspiring even today.

Thus, the senior member and first president of the Board, Dr. E. L. Griffin of Fond du Lac, consecrates the Board to its work as follows:

"No statute of the State embodies greater wisdom or touches a more vital interest of the people than the one under which we act. Impressed with the essential dignity of the offices we hold, while we distrust our own fitness for the work, I trust we shall be loyal to the truth and act wisely under the responsibilities which the law imposes."

Very keenly and clearly — perhaps too acutely, some physicians of today may think —they saw the place of preventive medicine. The first report, signed by the six medical men and one lay member, contains the following:

"The progressive spirit of the present era manifests itself in no direction more beneficiently than in its efforts for the prevention of disease and of premature death. . . . Men have learned, and are learning, the grand fact which is the underlying principle in all sanitary labor, that 'disease and death are in a great degree preventable . . .' It is the effort of the physician to cure, if possible, individual cases of disease. It is the labor of the sanitarian to prevent the very inception of disease. In this, his is the higher work, and it is also one which gives greater promise. Dealing largely with communities and with the influences affecting bodies of men in these efforts, their importance rises beyond that which seeks alone to cure the disease of the individual, and *preventive medicine* assumes a rank beyond the curative."

And over and over again in these early reports, these pioneer leaders of public health point to "*public sanitation* as the grandest and best gift a government can confer upon its citizens."

To see this early enthusiasm in proper perspective, it must be remembered that the primary purpose until comparatively recent times in the establishment of health departments lay in the quarantine of maritime ports and in the regulation of sewage and other waste disposal in cities. Wisconsin, in 1876, was almost wholly a rural state.

Moreover, when these pioneers entered upon their campaign of preventive medicine back in 1876, they had little of modern fact and technic to build upon. First of all, the specific bacterial causes of many diseases, such as, for example, the greatest of all, tuberculosis, had not yet been determined, and there was little scientific knowledge of the epidemiology of diseases. Second, they had no dependable vital statistics to work with. Thus, in the 1876 report the Board declares that "the existing law . . . though it has held a place on the statute books for many years, has been, so far as the recording of births and deaths is concerned, in most places practically a dead letter, and for all purposes of sanitary study absolutely valueless. This is evident from the fact that *two-thirds* of the counties make no return whatever of deaths, and more than one-half make no returns whatever of births." Third, no functioning local machinery existed for gathering statistics or securing desired action. Finally, there was little or no popular

conception of preventive medicine or local sympathy with preventive efforts. Thus, after a couple of years of ardent propagandizing, the secretary, Dr. J. T. Reeve, writes: "From many quarters word comes to us that 'our country is so exceptionally healthy that the appointment of a health officer seems entirely unnecessary.' . . . About one-third of all the townships reporting to this office make no report of the diseases concerning which special inquiry was made."

KEENNESS OF OBSERVATION

Yet, against these many obstacles they began their work—and began it with a vast amount of faith in the rightness of both the work itself and the methods they proposed to follow. Looking back from the vantage point of a generation or two of intensive public health work, we can endorse not only their enthusiasm but their judgment in most particulars. Especially can we endorse the keenness of observation and deduction on the part of some of these pioneer country practitioners.

Take, for eample, the following quotation in a letter to the Board from Dr. H. A. Youmans of Mukwonago:

"Not long after I settled in this country, I learned that many of the wells filled with surface water, and I soon discovered the cause.

"There are frequent depressions, or hollows, in the surface of the ground in this section of the state, generally but a few rods apart, frequently quite deep and without any outlet except by percolation.

"I discovered that the water did not accumulate in such depressions much, except when the earth was frozen, preventing its escape through the soil, and by examining the lowest portions of them I found a thin layer of loose vegetable soil and then a stratum of sand, more or less thick, which extended frequently for a long distance. In this way surface water finds its way into wells many rods distant, and I have often seen it colored like the water in the bottom of such depressions, and have colored the water in them myself and found that it made its way directly into wells through a stratum of sand beneath and between strata of clay, which seemed very impervious to water."

Not bad sanitary engineering research technic for a pioneer country doctor!

Even keen observation often led, of course, to wrong conclusions. Thus, Dr. Griffin declares that typhoid fever is "the legitimate outcome of a neglected privy; an open cesspool; a disgusting pig-sty; a contaminated well or a festering ground surface near the dwelling, which has been drinking in the kitchen slops for years, foul gases from which have been forced by moving currents of air into and through all the apartments of the home."

He was unimpeachably right as concerned the neglected privy and was quite as wrong in regard to the "disgusting pig-sty"; partially right and partially wrong concerning the ground seepage and the kitchen slops. It was, of course, this ground seepage into nearby wells and not the foul gases moving through the houses that bred disease.

This mingling of fact and error appears strikingly in the answers of local physicians and health officers to questionnaires on local health conditions sent out by the Board. Lacking dependable statistics, and having no authority to enforce their collection, the secretary, Dr. J. T. Reeve, resorted to questionnaire circulars, and printed many of the answers.

The following, for example, are extracts from correspondence in the 1878 report:

Almond (Dr. Guernsey)—"Pulmonary diseases have been prevalent owing, I think, to a greater amount of rain than usual."

Baraboo (Dr. Davis)—"During the winter and spring, pulmonary and bronchial affections were somewhat prevalent."

Oshkosh (Dr. Steele)—"Most prevalent have been phthisis, diphtheria, pertussis, lung and throat troubles, measles, scarlatina and mumps . . . a third [child] died within a month of acute phthisis, supervening upon diphtheria."

Waupaca (Dr. Taylor)—"Consumption prevails largely among the Norwegians—seldom among the Germans."

These extracts shed a dark, grim light on the toll that the mysterious disease tuberculosis took among Wisconsin pioneers.*

* In spite of the heavy death toll from tuberculosis which is evident from local correspondence in the early reports, it is interesting to note that a number of Wisconsin's early families migrated to the territory on account of the favorable reputation of its climate for the cure of tuberculosis. Thus, the father of Lafayette Houghton Bunnell, M. D. (later to become known as the discoverer of Yosemite Valley), brought his family to La Crosse, hoping that a son, daughter and grandson who had consumption would be benefited by the drier

climate of the upper Mississippi. The three died, however, in the spring of 1845, as so many migratory consumptives have done in our own generation.

The observations on greater morbidity among Norwegians than among Germans, and greater mortality in spring months, are sound, as we know today; but the reasons advanced—as, for example, greater rainfall—are often not sound.

VITAL STATISTICS

The first Board strove strenuously against the apathy of local officials for the systematic reporting of births and deaths. One of the papers in the first report, that on "Registration" by Dr. Joseph Hobbins of Madison, is a veritable paean of praise to vital statistics. Cannily, Dr. Hobbins devotes much space to the argument that building up a body of reliable mortality rates for Wisconsin, based upon records of births and deaths, would save Wisconsin citizens vast sums in lowered insurance rates because of the younger and stronger character of its settlers. "The sooner," he declares, "we can ascertain the average of life, then, in this state, the sooner will our people save from 20 to 25 per cent, or a great deal more than a quarter of a million dollars a year in their life insurance payments."

In fact, he declares, "the more one examines the subject of vital statistics the more truths—useful and profitable for us to know—are found to multiply themselves. It were indeed vain to look for any limit in the advantages to be derived by mankind from a sound and operative system of life and death registration."

It was a slow struggle, however, to convince many local officials, and even physicians. Thus, the Secretary, Dr. J. T. Reeve, in his 1877 report speaks of objections from physicians:

> "Not a few complain of the law as oppressive, and urge that the state, under penalties, demands of a citizen a service the performance of which involves no inconsiderable degree of labor and some actual expense, for which it offers no compensation."

Each year the Board sent questionnaires to clerks of local town boards, who, by previously enacted statute, were also clerks of the local Board of Health, although apparently many of them had never heard of this additional obligation until reminded of it by the Board. Prideful comments on local conditions often accompanied the replies. Thus, J. R. Dawes, Clerk of the Town of Wood, Wood County, declares in 1877: "I consider this one of the healthiest countries I ever saw." Likewise, Robert Severs, Clerk of the Town of Washington, Door County, which apparently even then was prohibition stamping ground, writes: "I believe a healthier town than ours would be hard to find. . . . We have had no saloons on the islands these thirteen years, which ought to be counted in our favor."

In many respects, the practices of the Board were very closely in line with the best modern thought on public health education. Take the utilization of the press, for example. The very first bulletin issued by the Board, even before physicians, clergymen and local town clerks were circularized, was sent to all the newspapers in the state, explaining the purposes of the Board and importuning their help.

Similarly, the first Board was keenly alive to the importance of teaching teachers to teach health. Dr. Griffin, as President, thus addresses his colleagues on the "science of hygiene":

> "There is need that it should form an essential part of the required study so soon as the pupil is of age to profit by such study. . . . No pupil should be considered qualified to go forth and teach who was not only well instructed in the 'facts, principles and dictates of sanitary science, but had also a proper appreciation of their value.'"

The next year the following resolution was passed by the Board:

> "*Resolved*, That a committee of three members of the Board be appointed by the President to report upon the extent to which hygienic studies are pursued in our public schools, and to make such suggestions as in their judgment are needed on the use of textbooks in the same."

VENTILATION

Ventilation—especially of schools and other public buildings—seems to have concerned the Board very greatly during its early years. In addition to the six physicians on the Board, there was one layman, General James Bintliff of Janesville, a Civil War veteran and an editorial writer on the

Janesville Gazette. His paper on the "Ventilation of Public Buildings and Dwelling Houses" is written from a wide background of historical knowledge and with much verve. Thus, for example, does he describe the relative success of heating arrangements in flimsily built houses: "When the largest fires were maintained it was barely possible for the resident, perpetually revolving before its blaze like a spitted turkey, to thaw one side of his refrigerated body before the other had become frozen."

General Bintliff and his colleagues seem to have been much concerned over the tendency of school architects and builders to meet the statutory requirement for a minimum number of cubic feet of air space per pupil by high rooms. "Not long since a teacher said, when speaking of a very costly structure," writes General Bintliff, "that the children taught therein must stand upon their heads if their feet were to be kept warm and their brains cool during tuition."

Questionnaire comments from local health officers seem to bear out the Board in its caustic criticism of ventilation in schools. "Many of the school-houses in this vicinity are sources of pulmonary disease from lack of ventilation and imperfect heating," declares the Health Officer at Hammond in 1877. Another health officer, at Prairie du Chien, writes: "The school houses are mostly badly constructed and ventilated. The vitality of teachers and scholars is badly depressed, and in the late months of winter bronchial catarrh and pneumonia are frequent with them." Or this from Benton: "During the winter it is not unusual to find from sixty to one hundred children crammed into one of these 16 by 24 pest houses, under the care of some unfortunate teacher, who is discarded after a six months' trial, because he cannot 'bring the children on.' Shades of Parnassus! how can any child 'come on' in such an atmosphere?"

It is surprising what a range of subjects the first seven Board members tackled. Even Mental Hygiene was familiar to them, although some of the ideas they expressed can hardly be considered sound today. Dr. Favill's paper in the first Annual Report, like the others, is phrased in pithy language:

> "Nature begins to help the little one's right early —to determine what is good for the body. Taste says sweet—and the body approves. Taste says bitter—and the body rejects. Not so with the mind. It hungers— but knows not sweet. It hungers— but knows not bitter. It will feed on garbage and grow."

A FALLACY

Perhaps the outstanding fallacy of these fathers of public health work in Wisconsin, aside from their repeated stress on the poisonous and disease-breeding influences of sewer gasses, is that of the effect of moisture upon the spread of diseases, particularly tuberculosis. "No water-soaked ground can ever be healthy, or fit for human habitation," the first report declares emphatically. "Soil moisture is well known to be one of the most prolific causes of the tubercular diseases which annually claim tens of thousands of victims." In his paper on "Sewerage and Drainage," Dr. Solon Marks of Milwaukee states that "Statistics have proven that surface-water is one prolific cause of consumption and kindred diseases." Evidently 'statistics' proved all kinds of things even in 1876!

In 1877 Dr. J. T. Reeve, Secretary of the Board, and three other members attended the fifth annual session of the American Public Health Association in Chicago. In his abstract of the proceedings, he writes:

> "Dr. Gihon of the U. S. Navy added some interesting corroborative testimony of the influence of dampness, showing the great increase of Pulmonary Diseases, in leaky vessels, or in vessels where the decks were kept constantly damp, while on vessels where the decks were kept perfectly dry, these diseases were comparatively rare."

Confirmation of these views on the relationship of moisture to tuberculosis seems to have come from local physicians and health officers. A Berlin, Wisconsin, physician is thus quoted in the 1878 report:

> "There has been a striking difference in the character of the diseases prevalent in these two sections for the past twenty-five years. The inhabitants of the woods and borders of the marshes have suffered largely from phthisis pulmonalis, while the residents upon the prairies and openings have been absolutely free from this disease, except in a few cases where a marsh or low ground was in close proximity to the dwelling. As the forests are

cleared up, the lessened amount of this disease is noticeable.

"The influence of shade and soil moisture in the production of consumption has been very clearly demonstrated, and the removal of well-developed cases only a few miles have been followed by remarkable recoveries."

However misguided we today feel the Board and its correspondents to have been in regard to the influence of marshes and moisture on tuberculosis, the discussion they evoked must have been desirable in awakening public opinion against the wretched drainage, sewage and well-water facilities which obtained in pioneer Wisconsin communities. Following are some quotations from local correspondents:

Green Bay—"The sewerage of this city is bad—there is almost none. Most of the city is built on flat land, which has a surface of alluvium varying from two to ten feet, and a substratum of clay from eighty to one hundred feet in depth. This alluvium is rapidly becoming saturated with filth, when the city will experience the dire effects of sanitary neglect."

Milwaukee—"The sanitary condition of this place can be made better by improving our system of sewerage. At this time most of the sewers in the city discharge their contents into an almost currentless stream, converting it into a cesspool from which large quantities of malarial poison emanate."

Watertown—"Better artificial drainage is all we need, and the prevention of the emptying of the same into an immediate river, from which is gathered the ice crop of every winter for the manufacture of beer and the use of our inhabitants."

Waupaca (Dr. Taylor)—"The only source of danger to the health of our citizens that is apparent at present, is the close proximity of privies and wells; in many instances they are not more than from *six to ten feet apart!*"

Sturgeon Bay—"Our town board has done a certain amount of sanitary work during the year, the most important being to prohibit the deposit of dead carcasses and other refuse upon the streets or in the Bay."

Other causes than moisture, however, were given for the prevalence of tuberculosis. The following, for example, from Dr. H. T. Godfrey of Benton, has a familiar sound to anybody in anti-tuberculosis educational work:

"Consumption is much more prevalent than formerly; this is attributable in many instances to the absurd insufficiency of dress for the proper protection of the chest and feet, especially of females, and to the attendance of young people thus insufficiently protected at balls, dancing parties, and crowded assemblies, generally in buildings where no attention is given to proper ventilation; they afterward ride home, perhaps a distance of five or ten miles, the thermometer being from 10 to 20 degrees below zero; much might be done to obviate this danger by holding such reunions in the afternoon."

One can imagine the venerable doctor, watching with frowning disapproval upon the spectacle of the gay young things of the eighteen-seventies, dashing about in their cutters and buggies, and decked out (but not sufficiently!) in their flounces and bustles and flower-decked hats — "raising whoopee" in the vogue of 50 years ago. One can also imagine the hoots of derision from the gay young things themselves at hearing the doctor's proposed remedy—"holding such reunions in the afternoon."

All in all, however, the reader gets a vivid and inspiring picture from going through the first reports of Wisconsin's pioneer State Board of Health. However wrong the founders may have been in some particulars, they were right in most important particulars—remarkably right considering the very limited light by which they had to work. They had a keen realization of the fact that "the pecuniary loss to a State from *preventable sickness*, annually exceeds its entire cost of government." Acting upon this conviction, they thought and wrote and worked for public health with courage, enthusiasm and vigor. Above all, as is fitting and proper for any public health body, they recognized the opportunity and the obligation of *teaching the people the truth, as they had it, or as they believed it to be.*

CARE OF THE INDIGENT

A comprehensive report on three types of plans for the care of the indigent which permit of free choice of physician and allow some degree of compensation for the work done, was made through the offices of the State Medical Society to the officers of all the county medical societies on November first. The report includes details of the Polk, Kenosha, Outagamie and Rock County plans and covers more than fourteen mimeograph pages. Copies may be obtained by any interested member by addressing the Secretary, 119 E. Washington Ave., Madison, Wis.

Medical Economics*

By W. G. RIOPELLE, M. D.
Beaver Dam

Upon searching literature in regard to the economic status of the healing art, one learns, with surprising interest, that the practitioners of the earlier centuries received the most fabulous fees. During the early and medieval periods of Arabia, Persia, Greece, and Central Europe, court physicians received large annuities while independent physicians collected as much as $100,000 for a single cure. Today the situation is quite different. Although there are some physicians who enjoy profitable practices, you would be surprised to know of the number who are not making their expenses. It is also disheartening to look up the estates of deceased physicians and find that, after years of faithful service, they have left but a meager dowry for the enjoyment of their families. We are informed by the Bureau of Medical Economics that the average net income of physicians in the United States is less than $5,000 per year. This average hardly enables one to support a family and save for retirement, to say nothing about returns on investment in educational preparation and equipment. Every young man, aspiring to the profession as a career, should be definitely informed that the chosen profession demands a life of unpretentious service to humanity, and that it proffers no schemes or racket for accession to financial power.

THE TRANSITION

Owing to the rapid and fundamental changes which are taking place in society, by reason of city growth, improved means of travel, and the wide-spread of education, organized medicine, like the rest of institutions, has been brought face to face with new and serious problems,—problems which affect its very existence. The public is commencing to realize the possibilities in medical science to limit human suffering and prolong life and the same public is demanding a readjustment from the profession.

Up to now, the medical profession drifted along insufficiently organized and without apprehension of these trends. Now then, if the medical profession is to continue on a sound economic basis, it must unshackle itself from the undermining interference of so many self-constituted agencies. Today there are no communities, however small, which do not support some lodge, church committee, woman's club, industrial unit, etc., to carry on some sort of health program. If you please, all have the most noble intentions, but unless they function under the guidance of the medical profession, they will frustrate their own purpose, for they are not sufficiently grounded in matters of health and disease, as well as of human behavior. Whenever any force, such as wealth, politics, social or industrial position, etc., assume control of the destiny of any human endeavor outside of its own realm, it is breaking a fundamental concept of human society and is bound to have disastrous effects.

Ever so often, the public is menaced by the suggestion of some unsound and fallacious theory designed to revolutionize scientific medicine. This is very well exemplified by an article of Swan Harding which appeared in the June issue of the Forum in 1930. In this article he attacks the integrity and present system of medical practice and makes suggestion of a new system. Likewise, in a publication of the Century Magazine of 1921, our University President, Mr. Glenn Frank, intimates that the present system is inadequate and offers "State Medicine" or a plan similar to Army practice as the eventual remedy. Indeed, such plans are conceivable but their practical application remains a question. As early as thirty-five years ago when prohibition for the United States was an ideal and a hope, there were well-meaning Puritans and orthodox believers, who vociferously proclaimed it as the great panacea for the country's moral decay. Now we have it with all its blessings and without a doubt, it has turned out to be the most marvelous stroke of hypocrisy

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that was ever perpetrated on a civilized nation. This is one of the many instances where practical application explodes a nobly conceived theory.

STATE MEDICINE

We need state control such as we have now to regulate public health and for the collaborating of statistics. I am convinced that the present system works efficiently and that it is continually winning more cooperation from the general profession. I know that the general physician who cooperates with the state department meets with courteous and helpful assistance. Whenever feasible, however, the state should refrain from setting up hospitals and staffs of physicians in direct competition to private practice for the purpose of rendering medical care to patients who can pay.

You all know that the federal government has inaugurated the policy of rendering medical and hospital benefits to war veterans with non-service connections. The measure, as it stands, is uncalled for and, furthermore, it was passed over the opposition of the profession. The veterans could have been given benefits just the same without encroaching upon the profession. It is just such practices that render the public susceptible to aid of any sort and, to my way of thinking, medical service donated under such or similar pretenses, is, indeed, anything but charity.

When we realize that federal, state and community practice has already increased to the astounding proportion of possessing and controlling over 60% of all hospital beds in the country, and that the character of their services is of such excellence that there is a growing demand for this type of service by the public, including patients who can well afford to pay, I want to tell you, my friends, that the tendency to State Medicine is not a negligible factor. On the other hand, when I observe members of the general profession vieing one another in their struggle for existence under an age-old competitive system which manifestly is on a receding tide, and when this same private practice suddenly finds that the majority of its clientele has suddenly become impoverished by a great depression, I wonder whether it is not best for the profession to study the merits of social practice before arraying itself against it. This question will be solved by the profession to a great extent but let us not forget that the general public will force its opinion.

COST OF MEDICAL SERVICE

The factor which has become the topic of greatest public consideration is the seemingly high cost of medical care. This opinion is conceived in the minds of irregulars, fanatics, and restless critics who with but superficial information manage to voice their criticisms through daily press and periodicals. The conception that the cost of medical care is too high for its worth and beyond reach for the mass of people is arbitrary and unfounded. The actual cost of medical service in the United States is approximately $20.00 per year per capita or $100.00 per family. This is indeed reasonable when compared with the cost of other necessities of life. It might be of public interest to know that the medical profession of the United States renders charity to exceed $300,000,000 each year. What other business or profession offers 30 to 40% of its entire efforts in charitable service? The source of trouble lies not in the actual cost of medical service, but in the fact that the entire expense is borne by those who are sick. It is estimated that approximately one-fifth of the people suffer with sickness each year and, naturally, the longer they are disabled the greater their expense and the less are they able to pay. It seems reasonable, therefore, that means be inaugurated whereby the cost of medical service be distributed more equally among the total population because sickness and disablement affects the economic life of the country as a whole. The public must also be reminded that the benefits of scientific advancement and discovery must of necessity be charged to the cost of medical service.

SUGGESTED REFORM

If the intelligence which worked out these life saving measures for humanity is to retain its unique character, far reaching reforms must be inaugurated. First of all, organized medicine must be more receptive of

the social changes which affect medical service. It must keep itself in closer touch with the public needs of the day. The statesmen of the profession who are large-minded, great-hearted, and tolerant of every man except the hypocrite, must step forward to continue the essential features of the past and develop absolute values born of the new age. All physicians possessing civic instinct must offer help by putting more interest in their county societies or by acting on public relations committees or in other capacities to cooperate with outside agencies in order to settle differences and to work out schemes of medical practice I know of no time when a well-organized committee on public relations could be of greater service than at the last senate session here in Madison to urge the passage of the bill to provide free choice of physicians under the Workmen's Compensation Act. The law as it is today is unjust because it denies the right of free choice to the workmen, and it furnishes occasions for the formation of petty rackets between arrogant insurance agents and solicitous physicians on the panel.

An important factor which demands attention is the distribution of service to all alike. It is estimated that approximately 30% of the people in the United States are without the range of adequate medical service. In every state in the union, there are communities which are entirely without medical service and are calling for help while in the cities doctors are crowding each other to the point of diminishing returns. When the public is taught to appreciate the value of service in the various fields of practice and there is just compensation for these respective services, the deserted districts will be replenished with doctors.

BUSINESS SIDE OF DOCTOR'S LIFE

In introducing a more personal subject for your attention, I should like to repeat an expression which is often heard, namely, that doctors have no business sense. Although it is true that the business side of the doctor's life is much neglected, it is not because he is devoid of sense. Owing to the doctor's profound interest in the profession, he puts all his effort to help others while he neglects his own personal welfare. Although it must be admitted that members of the profession are notoriously bad buyers of securities, still if I were to tell you that physicians and surgeons in the state of Wisconsin bought over $3,500,000 worth of insurance during the first four months of this year, it must also be admitted that not all are careless investors. It is my opinion that when one compares life insurance with any other form of savings and investments, it looms as the one gilt-edged piece of property. It is within the reach of everyone and at death, life insurance is a self-completing savings account as well as a self-administrating estate. It is the miracle of modern finance.

The doctor of today and the future must improve his financial standing if he wishes to render the best of service. It is the doctor of financial means who is apt to maintain efficient office help and equipment and acquaint himself with the newer methods of treatment.

Primarily, the medical schools need an economic department to give the candidates an insight into the business side of life. The physician already in practice should familiarize himself with the modern man's technique in contracting business and in collecting accounts. The average physician usually suffers the loss of a good many accounts merely because he lacks system in doing business. Medical service is one of the fundamental necessities of life and for that reason the physician is indeed entitled to something more substantial than a word of praise for services conscientiously rendered.

I believe we are approaching the time when Universal Insurance or perhaps a system of municipal doctors will be in force and then possibly four-fifths of the sufferers now facing hardships will cease to be charity charges on the profession.

FAMILY PHYSICIAN

It would be unfair to complete such a discussion without passing a remark on behalf of the family physician; the man, whom it is said, is doomed to disappear from our midst. This is a subversive trend which

must be attacked at once, for if we are to save our strongest heritage, we must save the family physician. It is true that the general practitioner has lost many of his clients who are now rushing to clinics and specialists. This may be his fault in part, but the principal reason is the lack of proper relationship which should exist between the two. If the general practitioner knows his limitations, and avails himself of clinics or specialists at the proper time, and they in turn extend proper respect and cooperation, the general practitioner will redeem his lost prestige. When this relationship openly exists, the public will lose the obsession of being "cliniced" for every ailment and this will tend to reduce the cost of medical care for the fact still remains that the general practitioner can take care of 85% of human afflictions at much less cost than at clinics or specialists. We must not lose sight of the fact that the front line of medical practice is at the bedside and office. That is where the highest type of general intelligence is needed, that type of intelligence, which, when imbued with the spark of divine faith, can encounter the problems of life with philosophical understanding.

In closing my remarks, I wish to say that the medical profession has fallen into an economic crisis which must bring about remarkable changes. There is every reason to believe that we shall be compelled to organize medical service on a scale beyond anything yet attempted in this country. The question is—how can the medical profession best serve the public and receive its just reward? It is up to the medical profession to decide whether or not it is best to accept socialized medical practice under government control or whether it can and will adjust itself, independently, to a new economic order that is already in the making. The achievement of this end is indeed an American enterprise which demands the democratic interest of the profession as a whole. If the task is not undertaken, it means that we must continue to struggle under the present chaotic system or submit to political dictatorship.

THE JOURNAL CLINIC

Foreign Body in the Cranial Cavity with Successful Removal; Case Report

By THOMAS J. SNODGRASS, M. D.
Janesville

H. S., #24572, reported for examination to determine the disability resulting from injury received August 30, 1928. In looking up the record of the original injury it was found he was taken care of at the time by the late Doctor Gerald K. Wooll, whose intention it was to report this very unusual case.

The patient was in an automobile which had a head-on collision with a truck. He pulled himself out of the wreckage, smoked a cigarette and assisted in getting other injured people into another car. He put his hand up to his forehead and felt something projecting from his skull. He got into the car with the others who were injured and was taken to Mercy Hospital. In the operating room it was discovered the threaded end of a wing-bolt was protruding through the skull just above the left frontal sinus. It was apparent the patient had struck the windshield with such force as to drive the large end of the wing-bolt through the frontal bone into the cranial cavity for a distance of one and one-half inches, the shaft of the bolt snapping off leaving only the small threaded end projecting out through the skin of the forehead.

Under general anaesthesia the bone was chiseled away sufficiently to allow removal of the foreign body. The brain was explored and loose pieces of bone removed. The wound was closed leaving a small iodoform gauze drain in place.

The original x-rays of the skull taken three days later have been destroyed, but are reported as follows: Postereo-anterior and lateral views of the skull taken on account of injury reveal a bone defect just above and to the outer side of the left frontal sinus. Viewed in the lateral position there are two elongated strips of bone showing an increased density to a point about one inch posterior to the main plate of the frontal bone and above the frontal sinus. This opacity appears to be due to fragments of bone driven in from the point of injury to the skull.

He was in the hospital two weeks and had no severe symptoms of any kind. Following the accident, however, within six months he started having headaches. These have occurred at various intervals since that time; are frontal in character, but are never severe enough to stop him from working. In his work as an engineer certain formulae with which he was thoroughly familiar drop from his memory, and it is necessary for him to refer to his notes. He states he notices his memory is impaired. He has had no dizziness, nor definite losses of consciousness. He also complains somewhat of his eyesight.

His examination, May 14, 1932, was negative except for the scar over his midforehead and a slight depression of his skull just above the left orbital ridge. His vision showed an error of refraction, and his left pupil was slightly irregular; visual fields and fundi normal. Stereoscopic radiographs taken in both directions reveal on the left side over the frontal sinus a triangular section of bone about one and one-half inches in length and about one inch in breadth at the

midline which is completely differentiated from the other part of the bone by its thick-

ness and the fact that it appears to project into the cranial cavity along its upper border. Immediately above this definite area there is a diminished density in the bone, but no actual bone defect. This is evidently the site of the old skull fracture. In the lateral view this triangular piece is seen to lie directly above the frontal sinus and project edgewise into the cranial cavity. There is a small spicule of bone external to this main piece just above the frontal sinus which appears to be separated somewhat. Immediately above the large piece of triangular bone in this view there is a diminished density which appears as a bone defect. After studying this old skull fracture in both directions stereoscopically it would appear that a piece of bone was broken off and pushed into the skull edgewise, and has remained in this position intact and healed in with callus formation.

The symptoms from which the patient is suffering at the present time are probably due to this old head injury. The interesting thing about this case, however, is the very unusual type of accident, and the very successful removal of this large foreign body from the cranial cavity.

Rupture of Gravid Uterus Following Previous Caesarean Section; Report of Case

By MALCOLM M. HIPKE, M. D.
Milwaukee

The occurrence of a rupture of the gravid uterus following a previous Caesarean Section brings us to the interesting subject of the treatment to be instituted in these cases.

Is the old saying of "once a Caesarean always a Caesarean" necessarily correct? Shall we operate on these cases a week or so before the estimated date of confinement or should we allow them to go into labor? Jellinghaus believes that all cases in which a former section has been performed for any cause, except a contracted pelvis, deserve a trial labor. While the patient is in labor he believes that the watching of the pulse rate is of cardinal importance. He says that about a half hour to an hour before rupture a rise in the pulse rate occurs. He cites one case in which he took the patient to the operating room and, upon getting into the abdomen, found the old scar open but the membranes still intact, making the performance of the operation very simple. I observed a case in which a rise of pulse rate had been present for three-quarters of an hour without being reported by the nurse and was found by the Doctor,—dead in bed from a ruptured uterus.

The question of whether a contemplated Caesarean following a previous Caesarean should be allowed to go into labor or not is also debatable. Some of the men of New York Lying-In Hospital prefer to have their patient go into labor before operating. This is done with the idea of securing dilatation of the cervix, thus insuring drainage. If a case comes into the hospital but is not in labor castor oil and quinine is given for induction. I remember one case in which we twice tried to induce labor without success. Following this we performed a section. There was no vaginal drainage for a few hours. The patient died on the fourth postoperative day of general peritonitis.

CASE REPORT

I submit the following case of a ruptured uterus following a previous Caesarean Section.

A para 3 aged 31 entered the Milwaukee General Hospital, July 1st, 1931, at 9 A. M. with the following history:

She had had two previous Caesarean Sections and an operation for a ruptured appendix. She had menstruated last sometime in October of the previous year and the estimated date of confinement was on or about July 20th. The previous night she had been visiting friends and was feeling fine on going to bed. At 2 A. M. on July 1st the patient was awakened by terrific pain in the lower abdomen. Having had frequent gallbladder attacks she thought it was a re-occurrence of the old trouble. Not wishing to disturb her doctor she waited until 7 A. M. to call him. During this time she felt herself getting weaker; vaginal bleeding commenced at about 5:30 A. M. The doctor arrived at 8 A. M. and after giving her a narcotic sent her to the hospital.

Examination revealed a well developed female of about 30 years of age in shock and under the ef-

(Continued on page 814)

THE STATE MEDICAL SOCIETY OF WISCONSIN

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EDITORIALS

PATIENTS VERSUS "CASES"

IT HAS always been the glory of clinical teaching in America to see a patient not merely as a "case" but as a personality, a human being, as well. The best clinical teachers in America, and there have been a host of such men, have always stressed this point of view. To mention only a few there have been Flint, Forscheimer, James Jackson, F. C. Shattuck, Billings, Faville, Weir Mitchell, and among living clinicians are Thayer, Barker, Morris and McCrae. No one has expressed the tradition of American medicine better in this regard in recent years than did Francis Peabody just before his untimely death.

Osler was the embodiment of this idea in theory and in practice, and his influence has been very great.

It has always been a shock to our sensibilities to observe some of the great clinicians of Europe at work in the wards of their great hospitals, where seemingly the patient was only a "case". I remember well going through the wards with Van Noorden and hearing him say, "Send this woman home, we cannot use her any more." The general attitude seemed cold and scientific with an absence of the human touch we were accustomed to.

The continental mind is persistent and thorough and will eventually arrive at its goal by pure science if not by intuition and natural feeling.

It was through the "Individual psychology" of men like Freud, Jung, and Adler, that the light first began to dawn abroad.

Now by means of the endocrines an approach is offered which makes the clinician aware that he is dealing not with a simple "case" but a very complex interacting combination of forces some of them chemical, some of them neurogenic which results in a peculiar physical and mental make-up, the constitution of the individual and his peculiar psyche. In other words the prophet from Vienna comes to America to disclose to us that a patient is a person after all not simply a "case". H. P. G.

AVOID THE ROUTINE

IN A RECENT number of the Journal of the American Medical Association Benjamin Goldberg writes upon the subject of medical teaching of tuberculosis. The present figures show little change from those of twenty years ago in regard to the prompt and early diagnosis of pulmonary tuberculosis by physicians the country over. Even now seventy per cent of patients in five of our large cities have moderate or far advanced tuberculosis when the diagnosis is first made.

Goldberg then goes ahead with a resume

of the kind of teaching which is being done and then outlines the ideal program making a plea for more and better teaching and for the greater utilization of sanatoria in the teaching of tuberculosis.

His conclusions are that the teaching of tuberculosis is very inadequate because of the failure on the part of the profession to diagnose early, and that we would have earlier diagnosis if we had better teaching.

Is it necessarily true that physicians fail because of lack of knowledge? Tuberculosis is a better worked and more highly organized field than any other one in medicine. If the same studies were made in other fields would we not find the same results?

Is the early diagnosis of cancer better made? I doubt it. Are gastric and duodenal ulcers diagnosed promptly? Probably not. Are such obvious conditions as pernicious anemia, diabetes, heart disease, and prostatic hypertrophy recognized early? May it not be true that only conditions like hypertension and goitre for which the eye or a simple instrument are necessary are invariably or generally recognized early?

This may sound like a rather severe arraignment of the profession, I wonder if it is. I don't believe it is. Neither do I think that we should condemn teaching methods in tuberculosis as the cause of our failure.

After all, the knowledge necessary to make early diagnosis of tuberculosis is not great nor is it difficult of achievement. As Goldberg states the public can be educated through the press and by well directed propaganda to recognize the early symptoms and seek earlier help. Are physicians so much duller?

Is not the difficulty rather a mechanization of our methods and an all too easy habit of superficiality? Don't we all tend to become routinists?

Eternal vigilance is the price of good medicine. Will better teaching create greater alertness? It will supply the necessary facts, but will it make them ever present in the mind of the practitioner. No. All too many physicians and educators look upon a course of lectures as the solution to problems in medical practice. The spoken word or the clinic is not the cure-all for our weaknesses. You can expose medical students to five years of the best possible training and yet the results will not be uniform. Many will apply all their accumulated knowledge and experience. Some considerable number, when they leave the laboratories, the hospital facilities and the innumerable assistants, will be unable to supply their place, and will see medicine being practiced by their older colleagues without these facilities. Commercial success does not always depend on knowledge and skill. They also will be compelled to go without most of the aids they were trained to use. The fault will not be because they got too little training. Indeed in a sense it may be due to the fact that they got too much, or rather that they haven't been given the right attitude. It is no easy matter for a young man without capital to enter the competition of medicine and maintain the standards that he was taught. All laboratory helps could be had in his training school, the hospital, with little thought of expense. What is to he to do? Get along without them. He has to and he finds it can be done and it doesn't interfere with his commercial success.

In order to practice medicine well we must be possessed of unusual determination and will power. We must avoid becoming routinists as we would avoid the plague. We must avoid mechanization of our minds and methods. We must be thoroughly alert and have all our knowledge on top all the time. Nothing can be pigeon-holed or allowed to become dusty. Our ideals must not be influenced by lower ideals about us. Commercial success must never corrupt our high standards. The practice of medicine must ever remain an end in itself. Great sacrifices must be made, but never at the expense of the patient or the highest ideals of the profession.

Knowledge is necessary and good teaching is indispensable, but the ability to use knowledge, and an alert mind and incorruptible idealism are equally indispensable and unteachable in a clinic or medical school. Better teaching is frequently needed but it is equally true that better organization of laboratory facilities and a better example might be set by those who are older and wiser in medical practice. H. P. G.

THE PRESIDENT'S PAGE

Reginald H. Jackson

CLOSE RANKS

IF, AS recently so well expressed by Olin West, secretary of the American Medical Association, "it is at once our privilege and duty to fight for the maintenance of the ideals and traditions of our profession" the time is rapidly approaching when every physician must conscientiously face and answer certain questions.

First: Just what have I done or do I intend to do towards fulfilling my share of this implied duty?

Second: Granted that in organized medicine chosen officials are expected to carry out to the best of their ability the tasks, however onerous, delegated to them by their fellows, what obligation rests on me as an individual member of the medical profession to accomplish something for the common good?

During the past year I have been surprised to learn by personal contact how many physicians there are in this state who have either allowed their membership in their county society to lapse, or, being eligible for membership, have not made application.

The usual explanations have been that they "could not see any good reason for membership",—"They could use the money which the membership dues called for to their own better personal advantage in other ways,"—"The dues were excessive and nothing beneficial was being accomplished by the inordinately heavy expenditure as revealed by the State Society budget."

Conversation with these physicians developing in a frank way a clear evaluation of what membership in their county society would return to them, resulted in a re-awakened sense of obligation on their part to join the rank and file of organized medicine. As I stated at the dinner of the county secretaries, if our profession is to maintain its present position in this state or hope to better it in the future, it can only do so through carrying on its present constructive program. This will inherently compel the continued expenditure of funds outside of and beyond those necessary, for the carrying on of a purely scientific program. The principal source of such funds to insure additional activities or permit of a lowering of individual dues must apparently arise in dues from an increased membership.

The mere contemplation of the effort to be made in the approaching legislative session to revise the statutes pertaining to the care of the indigent sick should convince every reputable and eligible practitioner in this state that it is not only his duty but that it will also prove a good investment for him to contribute his influence and strength in support of such a just and constructive measure by becoming an active unit of organized medicine.

I am convinced that the membership of our Society can be increased by several hundred in spite of the economic situation if these potential members are sought out and approached by the rank and file of our present membership in cooperation with the county secretaries.

Lest we forget and in order that you may present to those who have forgotten or do not realize what organized medicine in this state has actually achieved in furthering the best interests of all members of the medical profession, let me enumerate just a very few of these accomplishments.

1. Prevented imposition of a wholly unnecessary annual state narcotic tax of $10.
2. Aided the American Medical Association to secure reduction of the annual federal narcotic tax from $3 to $1.

3. Prevented the licensing of lay assistants as independent x-ray experts and prevented the licensing of numerous unqualified and incompetent to treat the sick.
4. Secured rulings and interpretations on federal and state income tax laws affecting the profession so as to secure proper and justified savings of thousands of dollars annually. Issues an annual review listing this information for the members.
5. Promoted the establishment of the Medical Library Service at the Medical School of the University. Commercial service of like nature costs upwards of $10 annually.
6. Secured an investigator for the State Board of Health to weed out gross forms of quackery. In most states this is, to our minds, unjustly financed by charging physicians an annual re-registration fee of from $1 to $5.
7. Defeated a bill proposed by compensation insurance companies designed to license industrial nurses to treat the injured except for narcotics and major surgery. Established Standing Orders for Nurses in Industry since approved by the State Licensing Board and enforced for protection of the injured.
8. Prevented legislation which would have cost the profession in excess of $60,000 annually (twice the State Society budget) for tests now made at the State Laboratory of Hygiene.

The enactment of the Basic Science law alone, while outstandingly legislation in the public interest, has brought to each physician in this State a far greater return,—regarded solely from the standpoint of an investment,—than the sum representeed by annual membership dues for many, many years.

While it may be difficult and even impossible to satisfy the ideas of all as to the proper function, policy or future program of our Society, we should remember that

> *"He who is false to present duty breaks a thread in the loom, and will find the flaw when he may have forgotten its cause."*

HENRY WARD BEECHER.

SOCIETY PROCEEDINGS

BROWN-KEWAUNEE

The October meeting of the Brown-Kewaunee County Medical Society was held at Green Bay on October 20th. A very interesting and instructive paper on "Tachycardia" was read by Dr. Louis M. Warfield of Milwaukee.

Dr. S. E. Gavin, Fond du Lac, district councilor, was also present and spoke on certain features of the State Hospital statute. W.E.M.

CRAWFORD

The annual meeting of the Crawford County Medical Society was held October 12th at Prairie du Chien. The annual dinner was given at the Savory Restaurant, the business meeting being held at the court house immediately after the dinner.

Those present included Drs. A. E. Dillman, Steuben, and the following from Prairie du Chien: O. E. Satter, W. T. Pinkerton, J. J. Kane, H. L. Shapiro and C. A. Armstrong. Dr. James M. Sullivan of Prairie du Chien and Dr. Emmett T. Ackerman of Gays Mills were elected to membership.

On motion it was voted to indorse the action of the two committees headed by Dr. R. H. Jackson and Dr. Gilbert E. Seaman reporting to the State Meeting and urging further efforts by the committees to so amend the laws by action of the legislature or the Board of Regents of the University to carry out the desires as expressed at the session of the State Society at Milwaukee.

It was also voted to indorse the action of the County Board of Supervisors if they decide to abolish the office of County Nurse and further, to advise action by the County Board to have our representatives in the legislature endeavor to have the laws amended to allow each county to care for its own indigent sick and be relieved of paying a tax necessary to permit the state to pay one-half of the expense of indigent cases sent to the Wisconsin General Hospital and that all cases of indigent sick possible be taken care of by the local hospitals.

Officers elected: President, Dr. J. J. Kane; Vice-President, Dr. H. L. Shapiro; Secretary and Delegate, Dr. C. A. Armstrong; Alternate, Dr. J. J. Kane. C. A. A.

LA CROSSE

A regular meeting of the La Crosse County Medical Society was held at the Cargill home, La Crosse, on October 18th.

Dr. Francis D. Murphy, professor of medicine, Marquette University School of Medicine, was the guest speaker of the evening. His subject was "Heart Disease,—Its Diagnosis and Treatment" and was discussed by Drs. James A. Evans and Martin Sivertson of La Crosse. It was a very interesting lecture.

The meeting was the largest held this year. Lunch was served following the general discussions.

G.D.R.

MANITOWOC

The Manitowoc County Medical Society held a luncheon meeting September 29th, with an attendance that was the best in years. It was decided to take over the work of the W. A. T. A. in the county and a committee composed of Drs. Kelley, Turgasen, Farrell, Barnstein and Cary were appointed to meet with the county health committee for final arrangements. Delegate R. W. Hammond reported on the state meeting. It is planned to revive the Society by having meetings every month and at least every other one to be followed by some social function. Dr. R. C. MacCollum offered suggestions as to "How to Improve County Society Meetings" while Dr. Ball gave a talk on "How You Look to an Outsider and How to Lick Contract Practice." Dr. E. J. Ball recently transferred from Wood County, having taken over the office of the late Dr. Kemper.

E. C. C.

MILWAUKEE

The first fall meeting of The Medical Society of Milwaukee County was held at the Hotel Pfister on October 14th, with 250 in attendance.

The program opened with the reading of the winning case reports submitted by Milwaukee hospital interns in a contest sponsored by the program committee.

The prize winners were as follows:

1st prize ($15.00), won by Dr. Maurice J. Ansfield, intern at the Milwaukee County General Hospital, for his presentation of "Brain Abscess Complicating Spenoidal Sinusitis."

2nd prize ($10.00), won by Dr. George E. Meloy, intern at the Milwaukee County General Hospital, for his presentation of "Report of a Case of Calcification of the Pericardium."

Honorable mention was awarded the following interns:

Dr. Samuel Rosenthal, St. Joseph's Hospital; Dr. L. S. Stern, Deaconess Hospital; Dr. Lawrence L. Grossmann, Mt. Sinai Hospital; Dr. Donald Paton, Milwaukee Hospital; Dr. E. R. Wernitznig, Deaconess Hospital; Dr. Elmer Kocovsky, Milwaukee County General Hospital.

Dr. M. E. Gabor spoke on "Direct Signs of Duodenal Ulcers," and Dr. L. M. Warfield, on "Tachycardia."

Dr. Gabor's paper was discussed by Dr. W. J. Egan.

Following the scientific program, the meeting adjourned to the Social Hour.

The next monthly meeting of The Medical Society of Milwaukee County will be held at the Hotel Pfister on November 11th. Dr. Robert B. Preble, professor of medicine of the Northwestern University Medical School, has been secured as the speaker of the evening. Drs. Benjamin Urdan and J. J. Eisenberg are also on the scientific program.

OUTAGAMIE

A special meeting of the Outagamie County Medical Society was held on September 29th to act upon certain economic matters of interest to the Society.

A special committee composed of Dr. V. F. Marshall, Dr. J. B. MacLaren and Dr. E. L. Bolton, all of Appleton, reported on the advisability of establishing a Credit Bureau, Collection Bureau and Finance Bureau for doctors' accounts. After wide discussion it was decided that a Credit Bureau and Collection Bureau were needed and the Committee was given power to formulate plans for the establishment of these two Bureaus.

It was unanimously decided that a Finance Bureau should not be established at the present time.

The Infant Welfare Committee was reported on by Dr. G. W. Carlson, Appleton. He pointed out that the infant welfare clinics would be held this year once a month as formerly. All the doctors of the Outagamie County Medical Society who desire to take part in this work will be given a turn alphabetically.

Report of the Public Relations Committee was given by the Chairman, Dr. J. L. Benton, Appleton, other members of the Committee being Dr. E. A. Rector and Dr. C. D. Neidhold, also of Appleton. This Committee has been very busy and has done some of the finest work for our Society that has ever been done. This Committee has been meeting with the Poor Commission of the city and county. Between them they have worked out a plan for the care of indigent sick. This plan is along the following lines:

1. Patient needing medical care chooses his own doctor and reports to him. The doctor then makes specific recommendations to the Poor Commission of what he thinks should be done for this patient.
2. The Poor Commissioner then O. K 's this work. If he is in doubt about the advisability of the work recommended he has the right to submit this case to one of the doctors on the Consultation Committee. This Committee is composed of doctors appointed by the Outagamie County Medical Society.

3. After the work has been done for the patient, the doctor submits an itemized bill but omits the charge.
4. This bill then goes to the Auditing Committee which is composed of five members, three appointed by the Outagamie County Medical Society, and two representatives of the Poor Commission. This Committee then decides what would be a just fee for the work done.

Dr. E. F. Mielke, president, appointed on the Auditing Committee: Dr. G. J. Flanagan, Kaukauna, 3 years; Dr. E. L. Bolton, Appleton, 2 years, and Dr. V. F. Marshall, Appleton, 1 year.

On the Consultation Committee: Drs. V. F. Marshall, J. B. MacLaren, E. L. Bolton, C. E. Ryan, all of Appleton; C. D. Boyd, Kaukauna, and W. H. Towne, Hortonville.

The Public Relations Committee further reported that a survey of the cost of medical care is being made in the county of Outagamie.

The relation of the family doctor to city and county doctor was then brought up. It was felt by some of the physicians of the county that the relations were not proper. It was decided to appoint a committee to investigate the matter. It was further decided that the committee should bring in recommendations in regard to proper relations between city and county physicians and other medical men.

R.V.L.

POLK

Mr. O. H. de la Gardie, district supervisor of the Bureau of Narcotics of this district, addressed the Polk County Medical Society on September 23, at Clear Lake. Mr. de la Gardie gave the members of the Society the "Dope" on the dope situation. The many interesting experiences of his department kept the members interested for several hours. The method of detecting the peddlers, apprehending and prosecuting them proved to be an "attention holder".

The Society formally agreed to form a corporation for the purpose of collecting physicians accounts. Membership in the corporation will be limited to members of the Society. It was agreed, however, that other physicians accounts may be collected by the organization.

The annual business meeting of the Polk County Medical Society was held on October 21 at the home of Dr. Geo. B. Noyes, Centuria. The following officers were elected: Dr. Geo. B. Noyes, President; Dr. Lorne Campbell, Clear Lake, Vice President; Mr. Geo. B. Larson, Frederic, Secretary-Treasurer, and Dr. H. C. Caldwell, St. Croix, to the board of censors.

Dr. R. G. Arveson, delegate, gave a report of the recent meeting of the State Medical Society.

At the close of the meeting the Society was presented with a cake bearing two candles, signifying the second anniversary of the Society. G.L.

RACINE

The Racine Country Club was the scene, October 13, of the Tri-County Medical society meeting, consisting of Walworth, Kenosha and Racine County Medical societies.

The afternoon meeting was given over to the social functions, including golf, cards, bowling, etc.

At 5:30 p. m. members and their wives sat down to a banquet. There were 115 in attendance. After the banquet, prizes for the best golf scores of the afternoon, which were donated by the Red Cross Drug company of this city, went to Dr. J. F. Henken, who turned in a low score of 77, and Dr. A. S. Pfeiffer with a score of 78.

The speaker at the banquet was Dr. Arnold Jackson of Madison, who gave an interesting paper on the status at the Wisconsin General Hospital.

The evening program began at 7:30, and the speakers were Dr. A. J. Patek of Milwaukee, who addressed the doctors on the subject of "The Heart in Surgery," and Dr. Ralph R. Reis, head of obstetrics at Michael Reese hospital, Chicago, who chose as his subject, "Recent Interesting Developments in Diagnosis and Treatment of Gynecological Subjects." Dr. Percy Bailey, who holds the chair of neurosurgery at the University of Chicago, spoke on the subject "Brain Tumors."

During the scientific program, the ladies formed a temporary organization which is to be the nucleus of the future Ladies' auxiliary, and will be expected to function in connection with the next year's American Medical Association convention to be held in Milwaukee. S.J.

TREMPEALEAU–JACKSON–BUFFALO

The Trempealeau–Jackson–Buffalo County Medical Society met October 7, 1932, at the Krohn Clinic, Black River Falls. Dr. C. F. Peterson gave the report of the meeting of the House of Delegates. Dr. Spencer Beebe spoke on the work of the Council. Dr. Elizabeth Comstock of Arcadia read a paper on "Placenta Accreta", and reported a case. This is the first meeting of the Tri-County Society held in Black River Falls, and all the counties were well represented. Following the meeting members were served to a chicken dinner at the Freeman Hotel as guests of the doctors of the Krohn Clinic. R. L. M.

WAUPACA

The Waupaca County Medical Society held a regular meeting at the New London Community Hospital following a 6:30 o'clock dinner on October 14th. Dr. Walter P. Blount, Milwaukee, talked on "Fractures of the Femur," illustrating his lecture with lantern slides. Following this, he gave a short talk on "Infantile Paralysis" showing his moving pictures on the treatment (Orthopedic) of deformities and paralysis. The Sisters and Nurses of the hospital were invited in to see the movie on the under water treatment of paralysis. F. J. P.

EYE, EAR, NOSE AND THROAT SOCIETY OF CENTRAL WISCONSIN

The Eye, Ear, Nose and Throat Society of Central Wisconsin held its fall meeting at Eau Claire, September 26, 1932. This meeting was to honor the

past President, one of the organizers of the Society, the oldest ophthalmologist in the state in years of practice,—Dr. A. L. Payne. There was a very large attendance.

Interesting clinics were held in the morning at the Sacred Heart Hospital by Dr. W. I. Lillie of the Mayo Clinic, Rochester, Minnesota, and Dr. Frank E. Burch, professor of ophthalmology of the University of Minnesota, and Dr. F. S. Cook of Eau Claire.

The afternoon session was well attended and the following program was presented:

"Muscle Tucking in Strabismus," Dr. Frank E. Burch, professor of ophthalmology, University of Minnesota, St. Paul. Discussion opened by Dr. Dean Smith, La Crosse.

"Intracapsular Extraction of Cataract", Dr. W. I. Lillie, Mayo Clinic.

Discussion opened by Dr. Albert E. Rector, Appleton.

"Lipiodol Displacement in Sinus Disease Diagnosis." Dr. F. S. Cook and Dr. J. C. Baird, Eau Claire.

Discussion opened by Dr. Lyman C. Copps, Marshfield.

Officers elected are the following: Dr. William J. Frawley, Appleton, President; Dr. W. M. Ruckle, Wisconsin Rapids, Vice-President, Dr. L. A. Copps, Marshfield, Secretary and Treasurer, and Dr. L. J. Friend, Beloit, censor.

After the meeting, the Society adjourned to the Eau Claire Country Club where dinner was served to forty. Dr. Payne was presented with a silver flask, by Dr. F. S. Cook, for the Society. F. S. C.

MILWAUKEE ACADEMY OF MEDICINE

The members of the Milwaukee Academy of Medicine held a meeting on October 18th at eight o'clock. Following the business meeting, Dr. Arthur I. Kendall, professor of bacteriology of Northwestern University Medical School, gave an address on "Recent Developments in the Field of Bacteriology."

MILWAUKEE OTO-OPHTHALMIC

The October meeting of the Milwaukee Oto-Ophthalmic Society was held at the Wisconsin Club on October 25th. Dinner was served at six-thirty o'clock.

The following program was presented:

"Orbital Abscess and Cellulitis," by Dr. E. R. Ryan.

"Acute Laryngotracheitis in Infants and Younger Children" by Dr. H. F. Wolters.

"Optic Neuritis with Involvement of Sphenoid Sinus" by Dr. T. F. McCormick.

NINTH DISTRICT

The autumn meeting of the Ninth Councilor District Medical Society was held at Wausau on October 13th. The following program was presented:

Diagnostic surgical clinic at St. Mary's Hospital at 4:00 P. M. by Dr. E. R. Schmidt, professor of surgery, University of Wisconsin Medical School, Madison.

"Silicosis", illustrated with x-ray plates, by Dr. Fred C. Prehn, Wausau.

Following the dinner at six-thirty o'clock at the Hotel Wausau, a paper on "Toxic Reactions Following the Use of Cinchophen" was read by Dr. W. C. Frenzel, Wausau.

A paper on "Appendicitis" was read by Dr. Erwin R. Schmidt, Madison.

TENTH DISTRICT

The thirty-second annual meeting of the Tenth District Medical Society was held in Eau Claire on September 29th. The morning program consisted of two dry clinics held at the Luther hospital. The first one,—a diagnostic medical clinic—was conducted by Dr. F. J. Hirschboeck of the Duluth Clinic, Duluth, Minnesota, and Dr. Robert McGandy of Minneapolis gave an emergency surgical clinic. Luncheon was served at the hospital.

The following were speakers on the afternoon program which was held at the Elk's Club:

"Medico-Legal Angles of Emergency Surgery" by Dr. Robert McGandy, Minneapolis. Discussion by Drs. Iver Stoland, Eau Claire; E. L. Mason, Eau Claire, Dr. F. E. Butler, Menomonie.

"Diagnostic Pitfalls" by Dr. F. J. Hirschboeck, Duluth Clinic, Duluth, Minn. Discussion by Drs. Oscar J. Blosmo, Menomonie; E. E. Tupper, Eau Claire; F. T. McHugh, Chippewa Falls.

"The Use of Forceps" by Dr. Wm. Dieckmann, associate professor of obstetrics and gynecology, University of Chicago. Discussion by Drs. E. P. Hayes, Eau Claire; C. H. Falstad, Eau Claire; C. N. B. Hatleberg, Eau Claire.

"Medical Economics in Wisconsin" by Mr. J. G. Crownhart, Secretary.

Election of officers then took place with Dr. F. G. Anderson of Eau Claire being chosen president and Dr. E. P. Hayes of Eau Claire, Secretary.

Following this program, the members adjourned to the Eau Claire Country Club where a nine-hole sweepstake golf tournament was held. Dinner and entertainment at the Club concluded the meeting. Upwards of one hundred physicians registered for the meeting.

UNIVERSITY OF WISCONSIN

A lecture on "The Changing Practice of Medicine" was given by Dr. Hugh Cabot before the University of Wisconsin Medical Society held in the Service Memorial Institutes building on September 29th.

MILWAUKEE NEURO-PSYCHIATRIC

The Milwaukee Neuro-Psychiatric and the Milwaukee Roentgen Ray Society were jointly entertained at a dinner meeting at Sacred Heart Sanitarium on Friday, October 28th. The speaker was Dr. William M. Craig of the neuro-surgical section of the Mayo Clinic. Dr. John Camp of the section on roentgen diagnosis was unable to appear on the program because of illness. J.E.H.

THE WOMAN'S AUXILIARY

MRS. FRED A. NAUSE, JR., Sheboygan, *President*
MRS. EBEN J. CAREY, Milwaukee, *President-elect*
MRS. WALTER FORD, Sheboygan, *Secretary*
MRS. RAYMOND G. ARVESON, Fredcric, *Treasurer*
MRS. WALTER JACKSON FREEMAN, Philadelphia, *National President*
MRS. JAMES BLAKE, Minnesota, *President-elect*
MRS. JAMES C. SARGENT, Milwaukee, *Editor*
National Convention, Milwaukee, June 1933

PRESENTATION OF GAVEL TO THE WOMAN'S AUXILIARY

The Woman's Auxiliary to the State Medical Society had the pleasure of receiving a gavel from the State Society at their general session at the College Woman's Club on Thursday, September 15th. In presenting the gavel, Mr. Crownhart said, "Just four years ago this month it was my privilege to suggest to the House of Delegates of the State Medical Society of Wisconsin that we needed the cooperative aid that only an Auxiliary could bring to us. It is indeed a privilege to speak today of an Auxiliary that is an accomplished fact and whose future will bring so much to the members of the State Medical Society.

"The last two years have demanded of each of us a recasting, if you please, of our standard of values. All of us have long been aware of an over-organization of men as men, of women as women, of physicians as physicians, and of all of us as contributors to the treasuries of many organizations and of our time without end. In the field of medicine and the public health, today as at no previous time, I think we see clearly that in the county medical society, the State Medical Society and the American Medical Association lies the first loyalty of the physician. These affiliated societies not only seek to perfect his scientific attainments but are constantly working to promote and protect his every interest in a sound program for constant advancement of the public health. So can I say to you that as the closest associates of physicians, as sharers in their gains, as partners in their work, and as conspirators to secure for them the rest they need but postpone to busy tomorrows,—your first interest, like that of the physician himself, may well be in this Auxiliary that seeks to give of its strength that the profession and public alike may prosper.

"I am here to present to you, in behalf of the State Medical Society of Wisconsin, an engraved gavel for the use of your organization today and in the years to come. May I suggest that it is not the gavel that is a token, but the markings of the engraver that are symbols of that deeper engraving of your devotion and sacrifices that will continue to contribute more largely than any scientific discovery to the well-being and progressive accomplishments of the medical profession of Wisconsin.

"I bring you this gavel for the Auxiliary, Madam President, with the cordial best wishes of the officers and members of the State Medical Society of Wisconsin."

The response of the President, Mrs. Gramling, follows: "In the name of the Woman's Auxiliary, I thank you, Mr. Crownhart, for this inscribed gavel. During the past four years, we, as an organization, have received much consideration from the State Medical Society of Wisconsin. I express to you, its representative, the hope that this gift will always inspire us with the lofty motives so idealized by the medical profession."

DEATH OF MRS. WALTER JACKSON FREEMAN

As the Journal goes to press the grievous word is received of the death of Mrs. Freeman, President of the Woman's Auxiliary to the American Medical Association. Mrs. Freeman died in Philadelphia on October twenty-sixth.

This is sad news to the entire Auxiliary and to the large group of Auxiliary women who had the good fortune to know her personally.

At the annual meeting in Milwaukee, Mrs. Freeman was the honor guest of the Woman's Auxiliary to the State Medical Society of Wisconsin. One of the last addresses presented by Mrs. Freeman was given before the House of Delegates of the State Medical Society of Wisconsin.

PRESIDENT'S MESSAGE

This article brings you my greetings as new president of the State Auxiliary, and it is with a great deal of enthusiasm that I begin my new duties as no doubt all new presidents do.

Our work for next year is quite well outlined. It was definitely decided at the board meeting in Milwaukee that the Woman's Auxiliary sponsor a "Health Essay" contest to be conducted in the sophomore year in all high schools where there are organized county auxiliaries. This work is being carried on by Mrs. Henry Gramling, our past president, under whose regime the idea originated. You will hear from her when the final plans are formulated.

Another of our projects for next year should be organization work. After having heard Mrs. Walter Jackson Freeman, our national president, whose enthusiasm for auxiliary work knew no bounds, we all feel that every county in Wisconsin should be informed of the wonderful advantages of a woman's auxiliary. The past president of the State Medical Society, Dr. Otho Fiedler, the advisory board, as well as Mr. Crownhart, are all very much "auxiliary minded", so that we can really feel we are an aid in the work of general organized medicine.

The national convention to be held in Milwaukee in June should be a real stimulation to the auxiliary in this state. The work necessary in staging the convention should bring us in closer contact and that is what we all desire. "To promote acquaintanceships among physicians' families so that fellowships may increase" is one of the objects of our organization. Each county auxiliary will be asked to do something to help entertain the thousand or more auxiliary members and I am sure we will all want to make the Milwaukee convention better, if anything, than the previous ones have been.

A complete list of our new state chairmen will be published in the very near future.

May I ask you to write to me frequently so that I might have your suggestions or questions, for the more closely we can keep in touch the more we will gain from each others ideas.

GREEN LAKE–WAUSHARA–ADAMS

The auxiliary to the Green Lake–Waushara–Adams County Medical Society met with the doctors at the Grand View Hotel in Ripon for a dinner meeting during the summer. The doctors and their wives joined in a bridge game at the home of Dr. and Mrs. Orvil O'Neal.

MARINETTE–FLORENCE

Some of the auxiliary members of Marinette–Florence County are carrying on auxiliary work within other organizations. Under the Public Health Committee of the Woman's Club they are working in the clinics. And through the aid of local physicians and hospital, other have secured registered nurses to write the histories for the W. A. T. A., which work previously had been done by the club members themselves. They have also subscribed to five copies of Hygeia which fulfills the subscription goal for this county.

MILWAUKEE COUNTY

The auxiliary to the Medical Society of Milwaukee County held its first meeting of the fall on October 14th at which time Dr. Elias P. Lyon, dean of medicine at the University of Minnesota, addressed a group of 115 ladies on the subject of "Nursing Education". Invitations were extended to about thirty-five superintendents of nursing schools and city and state nurses' organizations. Mrs. Fred A. Nause, Jr., state president, addressed the meeting expressing her appreciation for the work done by the auxiliary to make the state meeting a success and outlined her plans for the coming year.

The Milwaukee Auxiliary now has 229 active members, 10 associate members and two new applications for membership. Hundreds of letters and pamphlets have been mailed by the Public Relations Committee to women's clubs, parent–teacher associations and church guilds, informing them of the Speakers' Bureau and many requests for speakers have resulted. The Hygeia Committee aims to get 25 new subscriptions this year which is the quota for this county. They hope to raise sufficient money to enable them to place Hygeia in county schools and other places unable to subscribe to it.

ROCK COUNTY

The Rock County Auxiliary met at the Woman's Club, on Tuesday, October 25th, for their monthly meeting. Following dinner, bridge was played. At the business session arrangements were completed for the annual Thanksgiving party to be held this month as a joint social event with the Medical Society.

The Auxiliary plans to sponsor a public health speakers' bureau so that they will be in a position to furnish speakers on public health to the various clubs of the county, and in the near future they hope to publish pamphlets for the information of clubs.

WINNEBAGO COUNTY

The Winnebago County Auxiliary began its fall activities with a business meeting the last week of October.

TRI-COUNTY MEDICAL MEETING

At a Tri-County Medical meeting of Walworth, Kenosha and Racine County Medical Societies at the Racine Country Club on October 13th, the ladies formed a temporary organization which is to be the nucleus of the future ladies' auxiliary and will be expected to function in connection with the national convention to be held in Milwaukee next June.

TO COUNTY PUBLICITY CHAIRMEN

A request has come from Mrs. W. T. Martin, Central and North Central Regional Chairman, for interesting and unusual material to be collected from all county auxiliaries for the Regional Scrap Book. Reports of projects, activities and accomplishments of the auxiliaries together with pictures, press notices, programs and notes will add to the interest and value of our contribution from Wisconsin.

Will each county publicity chairman bear this in mind throughout the winter and begin now to note and collect this material and send it to the state publicity chairman at 720 Stowell Avenue, by March 15. 1933. We must constantly be looking for items of interest that will add to the value of this scrap book. It will be greatly appreciated if you will notify the state publicity chairman from time to time of the development of your collection.

NEWS ITEMS AND PERSONALS

Dr. J. J. McCarthy, who practiced in Sun Prairie the past four years, sailed on October 6th from New York for Hamburg, Germany. He expects to spend a year in postgraduate study in Vienna, Berlin, and London. Dr. McCarthy has disposed of his interests to Dr. M. E. Wyant, Madison.

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Dr. Elgie M. Houghton, formerly of Cassville, has purchased the practice of Dr. J. H. Fowler of Lancaster. Dr. Fowler is recovering from injuries received in an automobile accident in Colorado last summer.

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The following were speakers before the Biennial Conference on Social Work held in Milwaukee on September 23, 24 and 25, at the Y. W. C. A.:

Dr. R. E. Bushong, Milwaukee; Dr. Hugh P. Greeley, Madison; Mr. J. G. Crownhart, Secretary; Dr. C. F. N. Schram, Beloit; Dr. Dorothy R. Mendenhall; Dr. Charlotte Calvert, Madison, Dr. C. A. Harper, Madison, and Dr. R. A. Jefferson of Milwaukee.

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Dr. John Tasche, Jr., who recently returned from Europe where he spent fourteen months studying, has become associated with the Sheboygan Clinic. His parents, Dr. and Mrs. John Tasche of Sheboygan, were with him the last two months of his stay in Europe and returned with him.

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Dr. Adolph J. Schloemer of Jackson, accompanied by his son Howard, sailed for Europe on September 28th, where Dr. Schloemer will take postgraduate courses in Vienna. His son will also study medicine there.

During Dr. Schloemer's absence, Dr. H. E. Froeder of Milwaukee will have charge of his practice.

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Dr. Ralph M. Carter of Green Bay spoke on "The Development of Bone Surgery" before a meeting of the Green Bay Kiwanis Club in October.

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Funeral services for Mrs. A. Milton Cox, wife of Dr. A. Milton Cox of Albany, were held in the First Baptist Church at Albany on October 3rd and interment was made in Chicago.

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Dr. Kenneth J. Smith, formerly of Chicago, became associated with Drs. P. H. and James A. Hansberry of Hillsboro. Following his graduation from the College of Medicine, University of Illinois, Dr. Smith served internship at Cook County Hospital, Chicago, later becoming its resident physician in pathology and surgical pathology.

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Dr. and Mrs. Reginald H. Jackson, Madison, returned on October 8th from the east where they visited in New York City and Washington, D. C.

Dr. S. W. Forbush of Beloit attended special clinics for former interns at the Illinois Charitable Eye and Ear hospital in Chicago in September.

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Dr. and Mrs. J. A. Diamond of Frederic visited in Madison the latter part of September.

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Dr. and Mrs. Arthur Sullivan, Madison, accompanied by their children, Frances and Arthur, spent a ten-day camping trip in the Black Hills in early October.

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The State Laboratory of Hygiene, through its central laboratory at the University of Wisconsin and eight branch laboratories, tested 64,958 specimens for suspected germs and disease during the first six months of 1932, an official report shows.

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Dr. H. W. Johnson, formerly of the Mayo Clinic, Rochester, has become associated with Dr. B. I. Pippin of Richland Center.

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Dr. Paul L. Eisele, Ripon, was speaker at a meeting of the Ripon Kiwanis Club. Dr. Eisele spoke on the advancement of medical science in recent years.

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Mr. J. G. Crownhart, secretary of the State Society, gave a talk on public health before a noon meeting of the Kiwanis Club of Eau Claire on September 29th.

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An admission fee approximating expense of the first week of care is being charged incoming patients by St. Mary's, Madison General and Methodist hospitals in Madison under a new ruling made by the three institutions. Patients are now asked to make a cash deposit when admitted and a cash refund is made when the stay is shorter than expected.

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Three important exhibits from Wisconsin will be shown in the medical science exhibits of the 1933 World Fair, according to Dr. Eben J. Carey, of Marquette School of Medicine. Dr. Carey is director of the Century of Progress in Medical Science and recently returned from a second trip to Europe where he arranged for displays in the different countries.

Milwaukee will be represented by an exhibit from the Milwaukee public museum with Dr. S. A. Barrett, director of the museum, in charge. This exhibit will depict the practices of Indian medicine men of the North and South American tribes.

Another Wisconsin exhibit will be one on Dr. William Beaumont, in which the University of Wisconsin will collaborate with Washington University of St. Louis.

A third Wisconsin exhibit will be by Dr. Francis Murphy, professor of medicine at Marquette University School of Medicine, who will show the results of his studies in Bright's disease made at the Milwaukee County hospital during the last nine years.

Among the interesting exhibits which Dr. Carey has arranged for in his travels abroad is one by the Wellcome Research Foundation of London; Italy will send the Fathers of Medical Science exhibit which will show the work of such men as Vesalius, the "Father of Anatomy", and of Leonardo Da Vinci, famous painter. England will present a Lord Lister exposition. The life work of Pasteur will be demonstrated by the Pasteur Institute of Paris. An exhibit along similar lines will be received from Berlin in which Robert Koch will be commemorated.

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There were 2,210 deaths in Wisconsin in August, 34 more than in the same month last year, the State Board of Health reported recently.

Heart disease claimed the greatest number, 440 deaths. Cancer second in importance, claimed 292 which is 27 more than in August, 1931.

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Dr. H. Curtis Johnson of Madison was elected president of the Madison district of the Wisconsin department of the Reserve Officers Association.

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Dr. and Mrs. Gorton Ritchie have returned to Madison from Europe where they spent the past six months.

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Dr. Joseph Charles Dean, son of Dr. Joseph Dean of Madison, has joined the staff of the Dean Clinic, 113 N. Carroll Street, Madison. Dr. Dean recently returned from Philadelphia where he completed internship at Philadelphia General hospital.

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Dr. Robert Evans, 70, brother of the late Dr. Edward Evans of La Crosse died on September 16th at his home in Fort Dodge, Iowa. For the past forty-one years, Doctor Evans was a practicing physician of Fort Dodge, Iowa. He was buried in La Crosse.

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Among physicians who have just been granted a Wisconsin license by the State Board of Medical Examiners, the following have opened offices:

Dr. H. A. Gantz, Milwaukee, has opened an office in the Clarke building, Waukesha.

Dr. R. C. Morrison, Madison, is now located at 1253 Williamson St., Madison.

Dr. E. N. Krueger, Appleton, has announced opening of his office at 213 N. Oneida St., Appleton.

Dr. Owen C. Clark, Madison, has become a partner of Dr. H. W. Housley of Neillsville.

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Dr. Arthur Kovacs, formerly of Milwaukee, has opened offices in the Christoph building, Waukesha, for practice in eye, ear, nose, and throat diseases.

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Dr. N. A. Hill, a resident physician at Wisconsin General Hospital, opened an office in the First Central building, Madison, for the practice of gastroenterology.

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Dr. Wallace Nelson of Wisconsin Rapids was a speaker before a luncheon meeting of the Wisconsin Rapids Rotary Club in October. Dr. Nelson traced the history of surgical operations through the past centuries.

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Drs. J. B. MacLaren and V. F. Marshall of Appleton attended the annual meeting of the American College of Surgeons at St. Louis, Mo., Oct. 17 to 21.

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Dr. A. J. Pullen of Fond du Lac, who with his daughter recently returned from a trip to Europe, was the speaker at a meeting of the Kiwanis Club of Fond du Lac. He gave brief descriptions of the various countries visited and illustrated his address with motion pictures.

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Dr. J. E. Barnstein of Manitowoc celebrated his eightieth birthday anniversary at a family dinner held at his home on October 10th. Dr. Barnstein is the father of Dr. C. H. Barnstein of Newton, Wisconsin.

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An average of 69 indigent persons receive free medical services from the Rock County Medical and Dental associations at clinics held every Friday morning in the office of the health department of the city hall of Janesville according to records of the department. The clinics are under the direction of the members of the associations and are assisted by nurses of the city health department.

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Members of the Wisconsin State Nurses Association met in Oshkosh on October 17, 18 and 19, for their annual meeting. Dr. Millard Tufts of Milwaukee was one of the speakers on the program.

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Announcement has been made that the American College of Physicians will hold its seventeenth annual clinical session at Montreal, with headquarters at the Windsor Hotel, February 6-10, 1933.

Dr. Francis M. Pottenger of Monrovia, Calif., as President of the College, has charge of the program of general sessions. Dr. Jonathan C. Meakins, professor of medicine and director of the department, McGill University Faculty of Medicine, is general chairman of local arrangements and in charge of the program of clinics. Mr. E. R. Loveland, executive secretary, 133-135 S. 36th Street, Philadelphia, Pa., is in charge of general business arrangements, and may be addressed concerning any feature of the forthcoming session, including copies of the program.

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Dr. George H. Conklin, Superior, discussed "The Field Covered by the City Health Department" before members of the Superior Rotary Club on October 12th.

Dr. Sarah I. Morris, formerly of Madison, has moved to 505 Old Ford Road, Carroll Park, Philadelphia, where she will spend the winter.

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Dr. Hans H. Reese, Madison, was chosen president of the Central Neuropsychiatric Association at the annual meeting held at Rochester, Minn., Oct. 6th to 8th. He delivered an address entitled "Biochemical and Psychic Findings in Correlation to Changes in the Weather."

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Mrs. Albert R. Tormey, wife of Dr. Albert R. Tormey, Madison, died on October 15th after an illness of three weeks. Mrs. Tormey before her marriage was Miss Beatrice Barnes, daughter of the late Justice Barnes of the Wisconsin Supreme Court. She is survived by her husband and four children.

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Dr. C. C. Urquhart of Hurley was appointed health officer for Ironwood, Michigan.

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Dr. Cyril J. Radl, who recently finished internship at Milwaukee County General Hospital, has opened offices in Pardeeville.

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Dr. Charles Armstrong of the United States Public Health Service, Washington, D. C., gave a lecture on "Psittacosis" before the medical school students, members of the faculty and physicians in the Medical School building, University of Wisconsin, on October 17th.

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The executive committee of the University of Wisconsin Board of Regents has voted to accept a bequest of $10,000 from the will of the late Mrs. Mary C. Brittingham, Madison, for research work in medicine. The money will be set up as the Mary C. Brittingham trust fund.

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Dr. and Mrs. Franklin Nuzum of Santa Barbara, Calif., visited in October at the home of their parents, Dr. and Mrs. T. W. Nuzum, Janesville, and with Mrs. Nuzum's brother and sister-in-law, Dr. and Mrs. A. H. Pember, also of Janesville.

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Dr. Spencer D. Beebe, Sparta, visited the offices of the State Medical Society, Madison, October 19th.

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At a recent meeting in Chicago, the directors of Alpha Omega Alpha Honorary Medical Scholarship Society adopted the following resolution in recognition of the eminent services of the late Dr. William W. Root, Slaterville Springs, New York, the founder of the society and secretary-treasurer since its organization in 1902:

1. That all stationery and official documents of the society bear the words, "Founded by William W. Root, 1902.", and
2. That the annual lecture presented each year by a leading medical scientist, be known as the "William W. Root Alpha Omega Alpha Lecture."

The present officers of the society are Walter L. Bierring, Des Moines, president, Austin A. Hayden, Chicago, vice president, Josiah J. Moore, 55 E. Washington Street, Chicago, secretary-treasurer. Mrs. Root will continue as assistant secretary.

In addition to the officers, the directorate includes Ray Lyman Wilbur, Washington, D. C., Waller S. Leathers, Nashville, Louis B. Wilson, Rochester, Minn., and Willard C. Rappleye, New York City.

The committee on extension and policy comprises Elias P. Lyon, Minneapolis, Minn., chairman, William Pepper, Philadelphia, Irving S. Cutter, Chicago, Frederick C. Waite, Cleveland, and Thomas C. Routley, Toronto.

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MILWAUKEE

Dr. and Mrs. Harry J. Heeb, enroute to their summer home north of Eagle River, Wisconsin, on September 26th, were injured in an automobile accident six miles north of Oshkosh. Both were taken to an Oshkosh hospital where it was discovered that Dr. Heeb was suffering from a broken shoulder, and Mrs. Heeb from cuts and bruises.

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Dr. and Mrs. William L. Herner left the latter part of September for a short trip through northern Wisconsin.

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Dr. R. A. Jefferson, Medical Director of the Mental Hygiene Council, gave the first of his series of talks on "The Family" on October 11th. These talks will be given to a group of students of child training at the College Women's Club. Dr. Jefferson's subject was "The Family and the Genetic Dynamic Concept."

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Mr. Ernest G. Dallwig, father of Dr. Eugene L. Dallwig, died at his home, 4704 W. Wisconsin Avenue, on September 21st, after a long illness. Mr. Dallwig was a life-long resident of Wisconsin, and had lived in Milwaukee more than fifty years.

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Dr. R. G. Sayle, with a party of friends, left on September 29th, for a hunting trip to Merrillan, Wisconsin.

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Dr. Carl W. Eberbach gave an illustrated talk on the Grenfel Expedition at the meeting of the Business and Professional Women's Club at their meeting on October 11th.

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The appointment of Dr. Jack L. Kinsey as assistant medical examiner was announced on October 5th, by the city service commission.

Dr. Kinsey will assist Dr. R. C. Beulow, chief medical examiner, in making physical examinations of job applicants.

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A group of prominent men and women have been selected as speakers at the Y. W. C. A. each Tuesday on "Modern Trends in Thinking," as it relates to their various fields.

Dr. James C. Sargent, President-elect of The Medical Society of Milwaukee County, will address those attending the course on "Medicine."

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Mrs. Alice Bates Brown, widow of Dr. Frank E. Brown, who practiced medicine in Milwaukee for about thirty-five years, and who died in 1924, died at St. Mary's Hospital on September 29th, after an illness of two weeks.

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Dr. H. G. Decker was re-elected commander of the Bob Evans Post, No. 119, American Legion, at the annual election on September 20th.

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The Milwaukee Child Guidance Clinic, conducted by Drs. Samuel Plahner and Elisabeth Seiler, opened its third season in the lecture room of the Milwaukee Public Library on October 13th. The clinic, which is free, aims to help teachers and parents with problem children. It is patterned after those conducted by Dr. Alfred Adler and his followers in Vienna.

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Dr. and Mrs. Henry O. McMahon and family early in October moved from Fox Point to their new home on the Green Bay road.

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Dr. and Mrs. Stanley J. Seeger enjoyed a week's visit in New York recently.

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Dr. A. A. Pleyte of the medical staff of the Wisconsin Anti-Tuberculosis Association was elected Secretary–Treasurer of the Mississippi Valley Sanatorium Association on September 13th.

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The Matthew Keenan Health Center, located at N. Thirty-sixth Street and W. Auer Avenue, was dedicated on Friday, October 14th. Dedication exercises were held in the auditorium of the new building at two o'clock, after which the Health Center was open for inspection until five o'clock.

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The district meeting of the fourth and fifth districts of the Wisconsin State Nurses Association was held on October 11th, at the Health Service Building, 1018 N. Jefferson Street. "The Value of Alumni Participation" was the subject of the program presented, and Dr. James C. Sargent discussed "Its Application to Medicine" and Mr. James Taugher, of the Marquette University, spoke on "Its Application to Education."

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Mrs. Joseph L. Parr, former assistant superintendent at St. Luke's Hospital died in Madison, Wisconsin, on October 6th, at the age of forty-three years. Mrs. Parr at one time served as a nurse at Misericordia Hospital.

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On September 22nd, Dr. E. L. Miloslavich, director of the department of clinical pathology and medical research, at St. Mary's Hospital, spoke to the Whitefish Bay Cooperative Club on "Scientific Criminology." On September 26th, he addressed the Brotherhood of Salem Evangelical Church on "The Biological Aspects of Crime."

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At the thirteenth annual convention of the Wisconsin Chiropodist Society, held in Fond du Lac October 2–3, Dr. D. J. Ansfield spoke at the October 2nd meeting on "Practical Aspects of Weak Feet."

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The first postgraduate course in a series to be sponsored by the educational committee of The Medical Society of Milwaukee County got under way with the opening of the postgraduate course in orthopedics on October 10th, at the Milwaukee Academy of Medicine. Dr. E. W. Ryerson, professor of orthopedic surgery, Northwestern University Medical School, was the speaker of the evening. Drs. J. W. Powers, F. J. Gaenslen, H. C. Schumm, J. O. Dieterle, L. D. Smith, and C. C. Schneider are the instructors for this course, for which there is no charge, and for which the following physicians enrolled:

Drs. S. H. Wolter, Paul E. Aszman, H. E. Bardenwerper, B. I. Bender, E. P. Bickler, M. B. Byrnes, P. L. Callan, N. F. Dettmann, J. R. Dundon, L. A. Eisenberg, T. C. Clarke, R. W. Garens, D. J. Ansfield, H. R. Ausman, H. O. Zurheide, L. A. Bernhard, T. H. Burbach, R. H. Frederick, E. F. Cook, F. E. Drew, W. J. Carson, P. J. Eisenberg, T. G. Fitzgibbon, L. T. Gilmer, H. Webb, Edwin B. Gute, E. T. Harrington, G. H. Hoffmann, F. C. Heidner, Edward Jackson, C. D. Jurss, D. P. Thill, A. H. Heidner, H. Meyer Lynch, Benj. Lieberman, A. R. Langjahr, David Mehigan, P. J. Niland, Maurice Olsen, E. F. Peterson, D. F. Pierce, S. Plahner, G. J. Pugh, C. C. Reinke, J. E. Rueth, S. Salinko, H. F. Scholz, H. S. Schumacher, M. W. Sherwood, F. J. Stirn, A. L. Suhr, L. A. VanElls, R. A. Waite, M. E. Wiese, H. S. Smith, G. J. Gumerman, C. W. Harper, E. C. Heifetz, H. P. Haushalter, R. I. Hiller, L. W. Juergens, Bernard Krueger, P. M. Kauth, A. F. Kusterman, E. W. Lewis, T. J. Loughlin, J. J. McGovern, H. B. Miner, E. B. O'Leary, J. B. Ozonoff, R. C. Pfeil, W. B. Walton, Albert Popp, Ralph T. Rank, W. A. Ryan, J. A. Russell, E. J. Schelble, Irwin Schulz, Geo. J. Schweitzer, L. P. Stamm, W. L. Stranberg, E. X. Thompson, P. C. Wagner, W. J. Weingart, W. P. Zmyslony, A. H. Fromm, E. O. Gertenbach.

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Dr. John Freedman, formerly of Milwaukee, is practicing radiology at 1394 E. Jefferson Ave., Detroit, Mich.

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Dr. H. B. Podlasky and Dr. J. E. Habbe, attended the meeting of the American Roentgen Ray Society held in Detroit, September 27–30.

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Members of the medical staff of the Women's Evening Clinic held in Mount Sinai Hospital for the purpose of giving medical and dental care to women and girls who are unable to pay for such service, but who are employed, and cannot seek help at the day time clinics are the following:

Dr. Elëanore Cushing-Lippitt, director; Dr. Gail Moxon, internist; Dr. Rose Kriz-Hettwer, internist; Dr. Elsa Berger Edelman, otolaryngologist; Dr. Frances Johnson, gynecologist; Dr. Nina Tomkiewicz, gynecologist; Dr. Ida Schell, consulting internist; Dr. Elisabeth Seiler, psychiatrist; Dr. Florence MacInnis, consultant in pulmonary diseases.

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Dr. Samuel Plahner was the principal speaker at the meeting of the Cosmopolitan Club, held in the Wisconsin Hotel on October 13th. Dr. Plahner's subject was "The Need for Psychological Advice for Children at Home and in School."

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The marriage of Miss Eleanor Mary Seelman, daughter of Dr. and Mrs. J. J. Seelman, and Mr. Stuart Breitwish, son of Mr. and Mrs. A. J. Breitwish, took place at the bride's home on October twelfth.

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Mr. George A. Dundon addressed the members of the West Hopkins Street Parent-Teacher Association on October 20th on the subject of "The Milwaukee Health Department."

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Dr. Roy W. Benton, health commissioner of Shorewood, returned on October 31st from Washington, D. C., where he attended meetings of the Institute of Public Health and the American Public Health Association.

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The ninth annual convention of the American Interprofessional Institute was held in the Hotel Pfister, October 21st and 22nd.

Dr. W. J. Carson was a discussion leader at the Friday afternoon session.

Dr. L. M. Warfield delivered an address at the Saturday morning meeting on "The Relation of the Medical Profession to the Public."

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"The Quality Nurse Arrives" was the topic of Dr. Millard Tuft's paper given before the State Nurses Association meeting held in Oshkosh on October 17th.

Dr. Tufts is chairman of the Child Welfare and Public Nursing Committee of The Medical Society of Milwaukee County.

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Dr. and Mrs. Frank Wilson, of Paris, France, were Milwaukee visitors during October. Many social functions were given in their honor. They sailed on November 2nd for their home.

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Plans for the second of a series of postgraduate courses sponsored by the Educational Committee of The Medical Society of Milwaukee County are now complete.

Dr. William Allen Pusey, professor emeritus of dermatology at the University of Illinois College of Medicine, Chicago, has been secured to open the course on November the seventh.

The opening sessions of these courses are open to all physicians enrolled, following which the large group is split up into smaller units and assigned to local instructors. There is no charge made to Society members.

The following physicians, members of the Speakers' Bureau, represented The Medical Society of Milwaukee County, during the month of October.

On October 6th, Dr. D. W. Roberts spoke to the Parent-Teacher Association of the St. Sebastian School on the subject "Am I an Acceptable Parent?" and on October 19th he addressed the study group of the W. T. Sherman School Parent-Teacher Association on "The Mental Hygiene of Childhood."

Dr. Harvey E. Webb appeared before the Parent-Teacher Association of the Fifth Street School on October 18th, at which time he spoke on "Normal Living."

"The Tragedy of Appendicitis" was the topic of the talk given by Dr. P. J. Eisenberg to the Parent-Teacher Association of Lannon, Wisconsin, on October 18th.

BIRTHS

A daughter to Dr. and Mrs. M. M. Guzzetta, Milwaukee, on September 13th.

A daughter to Dr. and Mrs. A. R. Langjahr, Milwaukee on September 27th.

A daughter to Dr. and Mrs. D. J. Gardetto, Milwaukee, on September 28th.

A daughter to Dr. and Mrs. S. A. Morton, Milwaukee, on September 29th.

A son, John, to Dr. and Mrs. K. L. Puestow, Madison, on October 12th.

A son to Dr. and Mrs. S. E. Coffey, Milwaukee, on October 5th.

A son to Dr. and Mrs. Roy W. Benton, Milwaukee, on October 12th.

A son to Dr. and Mrs. Chester W. Long, Milwaukee, on October 15th.

MARRIAGES

Dr. Nathan E. Bear, Monroe, to Miss Ellen T. Trautman, Sheboygan, on October 15th at Chicago.

DEATHS

Dr. Malcolm G. Millar, Madison, died in a Madison hospital, Tuesday, October 11th.

Dr. Millar was born at Wilmington, Delaware, August 15, 1903, and came to Madison with his parents when a year old. He was a graduate of the Medical School, University of Wisconsin, 1928. The following two years, he served as surgeon in the United States Navy Medical Corps with the rank of lieutenant on the U. S. S. Antares of the Atlantic

fleet. The following year he joined the staff of the Lowe hospital at Mobridge, S. D., and when the new Children's Orthopedic hospital, Madison, was opened on May 1, 1931, was appointed chief resident.

He is survived by his widow and one son.

Dr. Peter Langland, Milwaukee, died at the Deaconess Hospital, Milwaukee, on October 11th.

Dr. Langland was born in the year 1852. After graduation from the Chicago Medical College in 1875, settled on the south side of Milwaukee where he practiced until his death. Despite his age he was in his office daily until his illness which occurred about a week before his death.

Dr. Langland was a former member of the Medical Society of Milwaukee County, the State Medical Society, and the American Medical Association.

He is survived by a son, Walter F. Langland, a brother and a sister.

Dr. William H. Willson, Fond du Lac, died on October 19th at the home of his son. He had been in ill health for the past three years.

The deceased was born Jan. 21, 1854, in the town of Le Roy, Dodge County. He was a graduate of The Hahnemann Medical College, Chicago, in 1875. He practiced in the town of Byron until 1893 and then came to Fond du Lac.

He is survived by his son.

SOCIETY RECORDS

New Members

W. Rydell, Rice Lake.
Geo. H. Irwin, Lodi.
J. H. Reynolds, 747 No. 27th St., Milwaukee.
Raymond P. Wiesen, 1348 N. 27th St., Milwaukee.
Alphons J. Hertel, 3702 N. Teutonia Ave., Milwaukee.
Edgar F. Andre, 5605, 6th Ave., Kenosha.
C. W. Aageson, 1 So. Pinckney St., Madison.
Frances A. Cline, State Board of Health, Madison.
F. T. Younker, Galesville.
L. N. Schnetz, 412 Sixth St., Racine.
David Atwood, 23 S. Pinckney St., Madison.
R. H. Stiehm, 1018 N. Jefferson St., Milwaukee.
M. J. Kuhn, 3525 W. North Ave., Milwaukee.

Changes in Address

Harry Shapiro, Friendship to Adams.
M. C. Crane, Washington Island to Taylor.
J. L. Rens, Lugerville to Weyerhauser.
Geo. W. Bartels, Janesville to City Hospital, Louisville, Ky.
George Klinger, Milwaukee to 318 South St., Waukesha.
L. W. Dudley, San Haven, N. Dak., to 1104 N. Marshall St., Milwaukee.
E. H. Lechtenberg, Evansville to Potosi.
H. B. Moe, Janesville to Deerfield.

» » » CORRESPONDENCE « « «

CRETINISM IN WISCONSIN

OSHKOSH CLINIC
19 Jefferson Avenue

Oshkosh, Wisconsin, October 20, 1932.

J. G. Crownhart, Editor,
Wisconsin Medical Journal,
Madison, Wisconsin.

Dear Sir:

If you consider the appended thought pertinent, I should be glad for you to print it in a subsequent issue of The Journal.

"Will Cretinism Become Endemic in Wisconsin?"

There are reasons why medical history of the future is likely to justify a negative answer to the question raised in Dr. C. H. Stoddard's paper at the recent annual convention.

Endemic cretinism prevails only in localities populated with a large percentage of "burnt out goiters". When couples of this description mate, cretinism in their progeny may be predicted in definite proportions (according to professor Dequervain). It has taken the Swiss people 600 years or more of in-breeding and iodine starvation to produce its "flock" of cretins.

The goiter belts of the United States are not sufficiently isolated for this in-breeding to occur. Moreover, foods raised in iodine rich soils are constantly being imported into these regions in large amounts by modern methods of quick transportation. As intimated in Dr. Stoddard's paper, prophylactic iodization of school children and pregnant mothers is becoming an established routine in most communities.

These combined influences will be sufficient, I believe, to prevent us from ever having more than the occasional sporadic cretin in at least the Great Lakes Goiter Belt.

Very truly yours,
E. F. BICKEL, M. D.

FROM LONDON

STATE BOARD OF HEALTH

Madison, Wisconsin, September 29, 1932.

Mr. George Crownhart, Secretary,
State Medical Society of Wisconsin,
Washington Building,
Madison, Wisconsin.

Dear Mr. Crownhart:

You will be interested to know that through the National Organization for Public Health Nursing we have had a request for a copy of "Standing

Orders for Registered Nurses Employed in Industrial Plants" from Miss Irene H. Charley, Honorary Secretary, Public Health Section, College of Nursing, London.

Cordially yours,
CORNELIA VAN KOOY, R. N.,
Director, Bureau of Public Health Nursing.

CvK:MB

"WELL MERITED DISTINCTION"

October 20, 1932.

Mr. J. G. Crownhart, Secretary,
The State Medical Society of Wisconsin,
Madison, Wisconsin.
My dear Mr. Crownhart:

I thank you very much for your letter of October 17 and your courtesy in sending me a copy of the October issue of the Wisconsin Medical Journal containing an account of the honor recently shown Dr. Mina B. Glasier by the State Medical Society of Wisconsin. My brother and I hold Dr. Glasier in the highest esteem and we are much pleased to learn of the well merited distinction the State Medical Society has conferred on her.

Sincerely yours,
W. J. MAYO.

BASIC SCIENCE EXAMINATION

STATE BOARD OF EXAMINERS IN THE BASIC SCIENCES
(Anatomy, Physiology, Pathology and Diagnosis)

Madison, Wisconsin, October 10, 1932.

Wisconsin Medical Journal,
Madison, Wisconsin.
Gentlemen:

The next examinations by the Wisconsin State Board of Examiners in the Basic Sciences will be held on December 17, 1932, 8 until 5, at the Hotel Pfister, Milwaukee, Wis.

Application to be made to Robert N. Bauer, secretary, 3414 W. Wisconsin Ave., Milwaukee, Wis.

Very truly yours,
ROBERT N. BAUER,
Secretary, Basic Science Board,
3414 W. Wisconsin Ave.,
Milwaukee, Wis.

Attorney General Rules that Sterilization Operations Not Required as Therapeutic Measures Probably Illegal

Holding that sterilization operations, except in the course of strictly therapeutic surgery, will probably be held by Wisconsin courts to be illegal, Mr. Fred M. Wylie, Deputy Attorney General, declared in October that discretion advises that neither poor relief officers nor physicians become parties to such operations except in the course of strictly therapeutic surgery. The ruling of the Attorney General was to Mr. Glenn R. Douglas, District Attorney of Washburn County, Spooner, Wisconsin, and because of the importance of the opinion it follows in full:

October 12, 1932.

Glenn R. Douglas,
District Attorney,
Washburn County,
Spooner, Wisconsin.
Dear Sir:

You ask opinion upon the following:

"We have advised the County Judge and the County Children's Welfare Board that Section 46.12 does not prohibit a sane person over twenty-one years of age from being sterilized, if he or she so wishes. We find no other section in the statute pertaining to sterilization. Please advise if our opinion was correct, and is a doctor protected in sterilizing persons who appear there voluntarily?

"Is it possible for a county to pay for sterilizing indigents who are now receiving county aid and who voluntarily offer themselves for sterilization?"

In *Moore v. State*, 3 Pinney 373, it was held that injury to the internal sexual organs of a female was within the mayhem statute, sec. 340.35, the court saying: (p. 375)

"* * * Nor can we see a reason to support the query made, that 'it is extremely doubtful whether an indictment will lie under our statute for disabling an internal organ of the body, like the uterus in a female.'

"Our legislature certainly gave the same protection to the internal organs of the female that it did to the external organs of the male, and there is no reason why it should not."

"Malicious intent" as used in Sec. 340.35, Stats., relates to a wrongful act intentionally done without just cause or excuse. *Keith v. State*, (Texas) 232 S. W. 321, 16 A. L. R. 949. Where the act is intentional the establishment of a motive is not necessary. *Cupps v. State*, 120 Wis. 504, *Manna v. State*, 179 Wis. 384.

Opinion was given by the attorney general, XVII O. A. G. 524, to the effect that an incompetent person could not be legally sterilized except under sec. 46.12.

Offhand, it is likely to appear that a competent adult may legally consent to be sterilized, not merely as a curative or preventive therapeutic, but solely to prevent procreation. I do not say that he or she may not, but there is sufficient contra indication in the law and in the disclosed attitude of some judges, to cause one to advise physicians that it is unwise for them to perform such an operation for sterilization purposes alone.

The question, in its present day application, is new, but it has perhaps its analogies in the common law, which is our law still, in the absence of constitution or statute on the subject. Analogous questions under the common law apparently have not been matters of recent litigation, and we must, perforce, go back into the musty volumes of the common law of early America and earlier England. Here is some of what we find (underscoring mine):

Blackstone, Book IV, Chap. XIV, Par. III:

"And also the law of England wisely and religiously considers, that no man hath a power to destroy life, but by commission from God, the author of it: and as the suicide is guilty of a double offence: one spiritual, in invading the prerogative of the Almighty, and rushing into his immediate presence uncalled for; the other temporal, against the King, who hath an interest in the preservation of all his subjects; the law has therefore ranked this among the highest crimes, making it a peculiar species of felony, a felony committed on one's self."

Blackstone, Book IV, Chap. IV, Par. I, and notes thereto (Cooley's, p. 1370):

"For mayhem is properly defined to be, as we may remember the violently depriving another of the use of such of his members as may render him the less able in fighting * * * So that, by the common law, as it for a long time stood, mayhem was only punishable with fine and imprisonment; unless perhaps the offence of *mayhem by castration*, which all our old writers held to be felony."

"But if the complaint be preferred against a woman that she had *mutilated a man*, she shall be adjudged to lose her hand, as the member with which she had offended."

"Sir Edward Coke (3 Inst. 62) has transcribed a record of Henry the Third's time (Claus. 13 Hen. III, m. 9), by which a gentleman of Somersetshire and his wife appear to have been apprehended and committed to prison, being *indicted for thus dealing with John, the monk*, who was caught in adultery with the wife."

1. Hawkins Pleas of the Crown 107 (1824):

"It seems, that such a hurt of any part of a man's body whereby he is rendered less able, in fighting, either to defend himself or to annoy his adversary, is properly a maim.

"And therefore, the cutting off or disabling or weakening of a man's finger or striking out his eye or foretooth, *or castrating him*, are said to be maims * * *.

"It is to be observed, that all maim is felony. It is said, that *anciently castration was punished with death*, and other maims with the loss of member for member. But afterwards, no maim was punished in any case with the loss of life or member, but only with fine and imprisonment.

"By the common law also, *if a person maim himself*, in order to have a more specious pretence for asking charity, or to prevent his being impressed as a sailor, or inlisted as a soldier, *he may be indicted*, and, on conviction, fined and imprisoned."

Cases are cited to all paragraphs.

Stephen, Digest of the Criminal Law, 6th ed., Arts. 225, 227, 228 (London, 1904):

Para. 225. "Everyone has a right to consent to the infliction of any bodily injury in the nature of a surgical operation upon himself or upon any child under his care, and too young to exercise a reasonable discretion in such a matter * * *. I know of no authority for these propositions, but I apprehend they require none. The existence of surgery as a profession assumes their truth."

Stephen, Digest of the Criminal Law, 6th ed. Arts. 227, 228. (London, 1904):

Para. 227. "Every one has a right to consent to the infliction upon himself of bodily harm not amounting to a maim. A maim is bodily harm whereby a man is deprived of the use of any member of his body or of any sense which he can use in fighting, or by the loss of which he is generally and permanently weakened, * * *. *Castration is a maim.* The positive of this Article is proved thus:—Injuries short of maims are not criminal at common law unless they are assaults, but an assault is inconsistent with consent. As to the definition of a maim, see 1 Hawk. P. C. 107. *He expressly mentions castration.*"

Para. 228. "*No one has a right* to consent to the infliction upon himself of death, or of an injury likely to cause death, in any case (other than those mentioned in Article 225), or *to consent to the infliction upon himself of bodily harm amounting to a maim*, for any purpose injurious to the public. Illustrations: (1) A and B agree to fight a duel together with deadly weapons. If either is killed or wounded his consent is immaterial. (2) *A gets B to cut off A's right hand*, in order that A may avoid labour and be enabled to beg. *Both A and B commit an offence.*

People v. Clough, 17 Wend. 351 (1837):

"In 2 Russell on Crimes, 289, a case is put, which the writer represents as a curious species of indictable fraud, viz, that of a man who maimed himself in order to have a more specious pretense for asking charity and Coke, Hale and Hawkins are referred to. This led me to examine the authors alluded to, and I find that none of them put the case on the *fraud*, but on the *mayhem*, and accordingly treat it under the title 'maiming'. They all go on the case statute by Lord Coke, who says: In my circuit in Anno 1 Jacobi Regis, in the county of Liecester, one Wright, a young, strong and lusty rogue, to make himself impotent, thereby to have the more color to begge, or to be relieved, without putting himself to any labour, caused his companion to strike off his left hand, and both of them were indicted, fined and ransomed therefore; and that by the opinion of the rest of the justices for the cause aforesaid! Co. Lit. 127, A. This and other cases were introduced by Lord Coke, with the observation,

'Note, the life and members of every subject are under the safe guard and protection of the King.' So that the indictment was clearly not for the fraud."

Bishop, Statutory Crimes, para. 744:

"Some have denied that, if she consents, it is indictable at the common law, unless she has arrived at the state of pregnancy termed quick with child. Com. v. Parker, 9 Met. 263; Com. v. Bangs, 9 Mass. 387; S. v. Cooper, 2 Zeb, 52; Smith v. State, 33 Me. 48. And Hale has on this subject the expression 'quick or great with child;' and Coke, 'quick with child;' but not in connections denying that the offense may be committed at an earlier stage of pregnancy. Others reject this distinction. 'It is not,' said Coulter, J., delivering the opinion of the Pennsylvania Court, 'the murder of a living child which constitutes the offense, but the destruction of gestation by wicked means and against nature. The moment the womb is instinct with embryo life, and gestation has begun, the crime may be perpetrated.' Mills v. Com., 13 Pa. St. 631, 633; followed by the North Carolina tribunal in State v. Slagle, 83 N. C. 630, 632; Taylor v. State, 105 Ga. 846, 33 S. E. 190. This, in principle, seems to be the reasonable and just doctrine."

Wharton's Criminal Law, 11th ed., pars. 182, 183, 767:

Para. 182. "Any injury committed in such way as to be an offense to the body politic can be prosecuted in defiance of the consent of the party immediately injured. Prize fighters, for instance, may agree to beat each other, and if this is done in private, and death or mayhem does not ensue, no prosecution lies at each other's instance, but it is otherwise when there is a breach of the peace; or when the fighting is so conspicuously brutal as to produce public scandal, or work public demoralization. *Consent cannot cure* duels or incest or seduction or adultery or *the maiming of another so as to render him unfit for public service, or such operation on women as prevent them from having children,* or operations to produce miscarriage, or (when this is by statute indictable) profligate dealings with minors. The reason is that parties cannot by consent cancel a public law necessary to the safety and morality of the state.

Para. 183. "*Nor as to inalienable rights.* * * * Inalienable rights are thus generally defined as life, liberty, and the pursuit of happiness. * * *

Para. 184. "Life is the first of these inalienable prerogatives. Thus, a man who kills another with the latter's consent is guilty of homicide. * * * We may, therefore, justly argue that if life be an inalienable prerogative, then taking it by self is a public wrong, and those who are accessories to this public wrong cannot plead in defence the suicide's consent.

"As will hereafter be more fully illustrated, consent will authorize a surgical operation in cases of danger, though the effect of such operation may be fatal."

Para. 767. "Consent of the party injured is no defense to an indictment for mayhem."

Wharton's Criminal Law, 11th ed., Par. 23. Absence of common law precedent not preclude a common law indictment in this country:

"It has been held indictable to cast a dead body into a river without the rites of Christian Sepulture; to be guilty of eavesdropping; to knowingly sell noxious food; to sell a wife; to disinter a dead body without proper authority; to give more than a single vote at an election; to be guilty of individual offensive drunkenness, or notorious lewdness, though on this point the better rule is that, to make the offense indictable, it must be such as to shock and insult, not an individual, but the community; to indulge publicly in profane swearing, or in foul and obscene language, so as to draw together a crowd in a thoroughfare, though the offense be not laid as a nuisance; and, in fine, to commit any act which from its nature must scandalously affect the moral and health of the community."

The foregoing contains abundant (and more of the same kind is available) for anti-minded judges to hold that sterilization, even by modern vasectomy or salpingectomy and of a competent adult consenting thereto, violates unchanged common law, or our present mayhem statute; which is largely word for word the Coventry Act, 22–23 Caroline II, c. 1. Sterilization has not been received by the courts with any open-armed welcome. Against the opposition of those of the public and on the courts who consider such interference with nature to be immoral or sinful, legislatures have so far made no great strides, and a great deal of what has gotten past the opposition in legislatures, has succumbed in courts. See the following:

State v. Feilen, Wash. ___, 126 Pac. 75, 41 L. R. A. (N. S.) 418;
Davis v. Berry, 216 Fed. 413;
Smith v. Examiners, 85 N. J. L. 46, 88 Atl. 963;
Osborn v. Thomson, 103 Misc. 23, 169 N. Y. Supp. 638;
Haynes v. Williams, 201 Mich. 138, 166 N. W. 938, L. R. A. 1918D. 233;
Smith v. Command, 231 Mich. 409, 204 N. W. 140, 40 A. L. R. 515;
In re Salloum (Mich.), 210 N. W. 498.

These are all cases of involuntary sterilization of incompetents and criminals, but they disclose the attitude of mind of the judges. In Michigan, the sterilization statute was finally sustained by a three to four decision. The majority and minority opinions (*Smith v. Command*, supra) exhibit little difference in understanding of law, but such opposite understanding of the subject matter as to make the same law have opposite consequences.

Even if we assume that the scientific and sociological view should prevail, nevertheless the law follows science, in some fields by perhaps a generation, for the law can reflect the advances of science only when they have been accepted by the people generally. Science may have a duty to educate the

law, but it has no duty to defy it, nor to take a serious chance with it. The consequences to a physician from the performance of an operation of this kind, should the courts hold it illegal, could be serious. Until the law is settled, it is not prudent for a physician to perform a sterilizing operation except within the ancient field of surgery, viz., when it is a therapeutic measure.

And if the poor relief officials should, as you suggest in your letter, become parties to the performance of such an operation, they, as well as the physician, would be liable to the penalties of the criminal law in case the courts should follow the letter of the old common law and hold that change in the application thereof can be only by legislative action.

It is not my intention in this opinion to take any position upon the religious and sociological phase of the question. It is my personal and official opinion, however, that the legal question is better to be settled in the legislature than in the courts with some well-intentioned public official or physician as the potential victim.

Very truly yours,

Fred M. Wylie,

Deputy Attorney General.

Caption: Injury to the sexual organs of male or female was mayhem at common law, and being an offense against public law, consent of the person maimed was no defense. Whether the sociological purpose of sterilization by the modern operations of vasectomy and salpingectomy, in view of modern surgical and sociological science takes these operations out of the prohibition of the criminal law, so that an adult competent person could consent thereto, Query? Discretion advises that neither poor relief officials nor physicians become parties to sterilization operations except in the course of strictly therapeutic surgery.

Basic Science Board Examination Questions, September, 1932

DIAGNOSIS

1. What findings are characteristic of a lower motor neuron lesion?
2. Give the physical evidences of cardiac decompensation.
3. What is the evidence for a left pneumothorax?
4. Define the following terms:
   - a. Acromegaly.
   - b. Anasarca.
   - c. Auricular fibrillation.
   - d. Cyanosis.
   - e. Emphysema.
   - f. Hypertrichosis.
   - g. Icterus.
   - h. Myxedema.
   - i. Nystagmus.
   - j. Orchitis.
   - k. Tabes mesenterica.
   - i. Urticaria.

PHYSIOLOGY

1. Outline nitrogenous metabolism.
2. What means may be used to decrease the coagulation time of blood either in or without the body?
3. What are vitamins? Dicuss their physiological significance.
4. Discuss the vasomotor system.
5. What are the mechanisms that bring about secretion of gastric juice and pancreatic juice at the proper time? What enzymes does each contain?
6. State the most important fact about each of the following subjects:
   1. Vagus nerve.
   2. Insulin.
   3. Thyroxin.
   4. The precentral-gyrus.
   5. The knee jerk.

HUMAN ANATOMY

There are but three questions; answer them carefully.

I. (50) Locate accurately the following structures:
   - (1) Cerebellum.
   - (2) Prostate.
   - (3) Duodenum.
   - (4) Thoracic duct.
   - (5) Superior vena cava.
   - (6) Thyroid gland.
   - (7) Gastrocnemius muscle.
   - (8) Transverse carpal ligament.
   - (9) Trigeminal or Gasserian ganglion.
   - (10) Ulna.

II. (20) Describe or show by diagrams the relation of the pleura to the lungs and mediastinum.

III. (30)
   - (1) Describe or show by a simple diagram of a sagittal section of the pelvis and abdomen the position of the normal non-pregnant uterus and vagina.
   - (2) Indicate the position of the uterus in late pregnancy.
   - (3) Give the important changes in uterine structure that occur during pregnancy. Include microscopical as well as gross changes.

PATHOLOGY

Answer briefly five questions.

I. Define: erythroblast; oedema; thrombosis; sarcoma; epithelium.

II. Generalized amyloidosis: causes, pathogenesis, effects.

III. Differential diagnosis between carcinoma and sarcoma. (Gross and microscopic).

IV. Typhoid fever and tuberculous enteritis: Gross and microscopic pathological differentiation.

V. Syphilitic aortitis: Gross and microscopic picture and results.

VI. What significance do you attach to a high reticulocyte count? In what conditions is it most often found?

VII. Prostatic hypertrophy: Gross and microscopic appearance and usual results.

VIII. Pneumonoconiosis: Pathological anatomy; Effect on patient.

PRESS SERVICE OF STATE MEDICAL SOCIETY

No serum does so much for public health as printer's ink

FOOD FOR THE CHILD

Madison, Wis., Sept. 22.—If the 270,000 children under the age of five years in Wisconsin were given a balanced ration, there would be fewer cross children and a healthier group of youngsters, in the opinion of the Educational Committee of the State Medical Society.

A list of nine elements of food which should go into a well-planned diet of the average normal child has been issued by the State Medical Society. These elements are: A pint and a half of whole milk a day, but not more than a quart. Fruit once or twice a day, including at least one raw fruit, such as orange, grapefruit, apple, or banana. One or more fresh vegetables a day, including a green leafy vegetable such as lettuce, spinach, or beet greens at least three or four times a week—preferably daily. A "starchy vegetable" such as potato, rice, or macaroni once a day. An egg daily. A serving of fresh meat or fish daily by the time the child is 18 months old; before that time, three or four times a week. Cereal once or twice a day. Bread and butter two or three times a day. Cod-liver oil daily (at least for children under 2 years).

"These foods are needed by the average child for his proper growth and development," declares the bulletin of the State Medical Society issued today, "and it is desirable that a child's daily diet should include them all. It should be remembered, however, that no harm will be done if occasionally one food must be omitted or if some times a child does not drink all his milk. Appetite for different foods varies from time to time and in different children, and it is not wise to insist that each food be eaten in the same quantity every day. A child will probably learn to like and eat well all these foods if they are given for the first time when he is hungry, if he sees others eating them with pleasure, and if meal-times are pleasant occasions without discussion of food, coaxing, urging, or scolding."

The bulletin also declares that children should not be permitted to exercise in the evening before going to bed.

"Restlessness and gritting of the teeth are often signs that the child has gone to bed too tired, not that he has worms, as is commonly thought," continues the bulletin. "The best treatment for such fatigue is a longer daytime rest than the child has been having and less excitement at the end of the day. Enlarged adeniods, improper foods for supper, too many or too few bedclothes, tight bedclothes, or too hot a room may make a child restless."

* * *

CANCER

Madison, Wis., Sept. 29.—The prevention of cancer depends upon the avoidance or correction of various forms of chronic irritation or inflammation which evidently favors the development of this disease. There are hundreds of people who have been treated for cancer in Wisconsin who have gone to a physician in time to effect permanent relief, the Educational Committee of the State Medical Society declared in a bulletin issued today.

"Cancers of the mouth, for example, are caused by a combination of bad teeth, tobacco and chronic infection," continues the bulletin. "The importance of good dentistry and a clean mouth in this connection is obvious.

"Most cancers of the skin develop in other abnormal conditions of the skin which have preceded them. The correction of such conditions will largely prevent the occurrence of skin cancers.

"The majority of cancers occurring in the genital organs of women are preceded by chronic inflammation due to injuries received at childbirth or to some form of infection. The proper repair of such injuries and the treatment of such infections will do much to prevent this type of cancer in women.

"In connection with the breast, there is one practical precaution to be taken which will be considerable protection against cancer in that organ: every definite tumor occurring in the breast should be removed. Such a tumor is always questionable. It is never possible to be certain that it will not become cancerous, if it is not already cancer; and its local removal and microscopic examination is therefore the safest procedure. Permitting such a tumor to remain without attention may result in an entirely avoidable disaster.

"A periodic physical examination by a physician who is familiar with the predisposing causes of cancer will do much to prevent the occurrence of many cancers by early recognition of predisposing factors.

"Preventable types of cancer, comprising possibly one-half of the total number of cases, and causing about one-third of the deaths, furnish the most hopeful field for the diminution of suffering and the reduction of mortality from this devastating disease."

* * *

SORE THROAT

Madison, Wis., Oct. 6.—That sore throat is not a disease in itself but is a symptom of an infectious process which may be mild or severe and needs immediate attention, was the statement issued today by the Committee on Health of the State Medical Society of Wisconsin.

"Sore throat," declares the bulletin, "is simply a convenient term under which the ordinary person groups any inflammatory condition of the tonsils or the throat. The inflamed area may be localized to one particular spot or it may be more general; it may involve only that part of the throat visible through the mouth or it may extend up and involve that part of the throat or pharynx which lies behind the nose or it may go downward and involve the larynx or the organ of speech which lies inside a cartilaginous box known commonly as 'Adam's Apple'.

"The symptoms of sore throat are so well known that it is unnecessary to mention them. The causes, however, you should know something about. In the first place, sore throat is not a particular disease in itself; it is a symptom of an infectious disease. This infection may be relatively mild or it may be of a serious nature such as diphtheria. Again, one type of sore throat may be merely a local infection while another type may be a part of a generalized disease. Quinsy is an example of the former. It is a local abscess behind the tonsils and while it is a most distressing ailment for the one who has it, the general symptoms accompanying it rapidly clear up when the abscess is opened and the pus is allowed to drain out. On the other hand, sore throat is almost invariably an accompaniment of scarlet fever, and, although the local symptom may not be particularly bothersome, it is no indication of the severity of the disease itself.

"The first manifestation of many other diseases may be sore throat; in fact with some, except for fever, it may be the only symptom of which the patient complains. Some of the diseases ushered in

(Continued on page 810)

THE JOURNAL BOOK SHELF

Physical Therapeutic Technic. By Frank Butler Granger, A. B., M. D., late physician-in-chief, Department of Physical Therapy, Boston City Hospital; director of Physical Therapy, United States Army; medical counselor, United States Veterans' Bureau; Member of Council on Physical Therapy, American Medical Association. W. B. Saunders Company, Philadelphia, and London.

Minor Surgery. By Frederick Christopher, S. B., M. D. Assistant professor of surgery at the Northwestern University Medical School, Chicago; attending surgeon at the Evanston (Ill.) Hospital. Second edition, reset. With 687 illustrations. Price $10.00. W. B. Saunders Company, Philadelphia, 1932.

BOOKS RECEIVED FOR REVIEW

Pharmacology of the Medicinal Agents in Common Use. By Stanley Coulter, Ph.D., Sc.D. Published by Eli Lilly & Company, Indianapolis, Ind.

Functional Disorders of the Large Intestine and Their Treatment. By Jacob Buckstein, M. D., instructor in gastrointestinal roentgenology, Cornell University Medical College; alimentary tract division, roentgen department, Bellevue Hospital. With 60 drawings and 40 reproductions of radiographs. Price $3.00. Harper & Bros., New York and London.

Internal Medicine; Its Theory and Practice. Contributed by 27 American authors. Edited by John H. Musser, B. S., M. D., professor of medicine in The Tulane University of Louisiana School of Medicine; senior visiting physician to the Charity Hospital, New Orleans. Octavo, 1316 pages, illustrated. Cloth $10.00 net. Lea and Febiger, Washington Square, Philadelphia, Pa.

Hospitals and Child Health. A publication of the White House Conference. Containing reports of the subcommittees on hospitals and dispensaries; convalescent care, and medical social service. Price $2.50. The Century Company, 353 Fourth Avenue, New York, N. Y.

The Curative Value of Light. By Edgar Mayer, M. D., consultant in light radiation to the American Medical Association Council; medical director of the Northwood Sanatorium and the National Variety Artists Sanatorium, Saranac Lake, New York. Price $1.50. D. Appleton & Co., New York and London.

The Failing Heart of Middle Life. By A. S. Hyman, M. D., cardiologist, Beth David and Manhattan General Hospitals, and A. E. Parsonnet, M. D., attending physician and cardiologist, Newark Beth Israel Hospital, Newark, N. J. With 166 illustrations, some in colors. Price $5.00 net. F. A. Davis Company, 1914 Cherry St., Philadelphia, Pa.

BOOK REVIEWS

Any scientific publication reviewed in this col- such inspection should be directed to the Medi- umn may be obtained for inspection. Orders for cal Library Service, 424 N. Charter Street, Madison, Wis.

A Text-book of Pathology. An Introduction to Medicine. By William Boyd, M. D., M. R. C. P. Ed., F. R. C. P. Lond., Dipl. Psych., F. R. S. C. Professor of Pathology in the University of Manitoba; Pathologist to the Winnipeg General Hospital, Winnipeg, Canada. Published by Lea & Febiger, 1932. Price $10.00.

In his preface the author announces this text as a work primarily for students and not as a reference pathology. His attempt is to give an introduction to medicine by creating a living functional as well as morphological pathology. In general he has succeeded. One has become accustomed to expect good books from Dr. Boyd, whose facile pen and ability to create word pictures have won general admiration. This is another good book, yet one could wish that it were better. The reviewer has no complaint to make of healthy differences of opinion on theoretical and controversial points, but he does object to the fact that in telling his story, the author has been careless in the matter of descriptive pathology. There is in many places a lack of preciseness and accuracy in his descriptions. A single example containing at least two errors, may serve to illustrate the reviewer's point, to wit: "Each granulation (of granulation tissue) consists of a capillary loop supported by a few connective-tissue cells". While pathology should be presented as a living subject, the reviewer believes it can only be so presented on a basis of accurate morphology. C.H.B.

Introduction to Dermatology. By Richard L. Sutton, M. D., professor of diseases of the skin, University of Kansas School of Medicine, and Richard L. Sutton, Jr., M. D., visiting dermatologist to the Kansas City General Hospital. With 183 illustrations. Price $5.00. C. V. Mosby Company, St. Louis, 1932.

This manual is a condensed, well written edition in miniature of the 8th edition of Sutton's Diseases of the Skin. It was compiled largely by Dr. Richard L. Sutton for use by medical students, the idea being to presnt the essentials of dermatology in such a way that the student's approach to this difficult subject could be made without his being hampered by reading a mass of descriptive material of interest

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only to the confirmed specialist. The result is a compact manual of 565 pages, which is made up of 18 chapters arranged in true orthodox style. The first seven chapters deal with the anatomy, physiology, etiology, symptomatology, diagnosis, treatment and classification of dermatoses. All this is neatly disposed of in 77 pages while the balance of the work is concerned with descriptions of the clinical diseases. These are grouped in chapters on hyperemias, inflammations, hemorrhages, hypertrophies, etc.; the individual disorders being discussed in brief paragraphs relating to the definition, pathology, diagnosis, prognosis and treatment.

The work is instructively illustrated and should prove to be of great aid to the beginner in medicine. R.L.Mc.

Hospitals and Child Health. A publication of the White House Conference. Containing reports of the subcommittees on Hospitals and dispensaries; convalescent care, and medical social service. Price $2.50. The Century Company, 353 Fourth Avenue, New York, N. Y.

This is one of the valuable studies made under the auspices of the White House Conference on Child Health and Protection. The chairman of the Committee on Medical Care for Children was Philip Van Ingen of New York. The chairman of the Subcommittee on Hospitals and Dispensaries was Clifford C. Grulee of Chicago. The chairman of the Subcommittee on Convalescent Care was Adrian V. S. Lambert of New York. The chairman of the Subcommittee on Medical Social Service was Ida M. Cannon of Boston. This volume embraces the reports of these three subcommittees.

The report of the first subcommittee gives valuable statistical data on hospitals, dispensaries, and posture clinics from the standpoint of provision for children. Better organized service rather than more beds is urged and better provision for teaching pediatrics for medical students and interns and for nurses.

The report of the second subcommittee urges better provision for convalescent homes for children, the report of the third subcommittee, better organized social service in urban and rural districts.

C. R. B.

The Curative Value of Light. By Edgar Mayer, M. D., consultant in light radiation to the American Medical Association Council; medical director of the Northwood Sanatorium and the National Variety Artists Sanatorium, Saranac Lake, New York. Price $1.50. D. Appleton & Co., New York and London.

Dr. Mayer's long experience in heliotherapy and other therapeutic applications of light fits him admirably for an authoritative discussion of the subjects with which he deals in this new book.

The chapters deal with From Sunlight to Sun Lamp, Action of Light on the Body, the Sun Bath, The Value of Light in Bone-Substance Deficiency Diseases, Light in Relation to Tuberculosis, Disputed Claims of Benefits Ascribed to Light in Other Diseases, Sun-Lamp versus Sunlight, and a discussion of Vitamins and irradiated substances.

The whole book is written in quite a popular style, and the topics are well discussed. While the book is valuable to every physician, it is also quite suitable for general reading on the part of the laity, nurses, and medical students. The subjects are discussed very conservatively, and contra-indications as well as indications are forcibly presented in connection with all forms of light treatment.

The book contains only 169 pages, and is printed in type of a generous size, which makes for easy reading. It is a valuable addition to the literature on light therapy. J. C. E.

Clinical Endocrinology of the Female. By Charles Mazer, M. D., assistant professor of gynecology and obstetrics, Graduate School of Medicine, University of Pennsylvania; gynecologist to Mt. Sinai and to Northern Liberties Hospitals, Philadelphia, and Leopold Goldstein, M. D., demonstrator of obstetrics, Jefferson Medical College. Illustrated. W. B. Saunders Co., Philadelphia, 1932.

The title suggests exactly what may be expected in this volume. The authors have provided a careful and accurate explanation of the anatomy, physiology, and pathology of the problems touched upon. The text is very readable without extensive experience in the original literature of either gynecology or endocrinology. In the latter field the publication has been so voluminous in recent years that it is difficult for any one to keep abreast of all the papers in such an important branch as sex physiology. The extensive bibliography in this volume makes it a serviceable guide to this periodical literature.

The smaller volume by Graves, on Female Sex Hormonology, by the same publishers is recommended for all practitioners as well as students of medicine. This more extensive volume by Mazer and Goldstein will serve as a useful handbook for reference to many details. It will be desired by the gynecologist and obstetrician who desires to do more than surgery. The internist who realizes the medical aspects of gynecology should not be without the volume as a part of his library for diagnosis and for guide to therapy. E. L. S.

Gastrointestinal Tract. By William Gerry Morgan, M. D., professor of gastroenterology, Georgetown University Medical School; consulting physician, Georgetown University Hospital, Garfield Memorial Hospital, and Gallinger Hospital, Washington, D. C. 32 illustrations. Price $5.00. J. B. Lippincott Co., Philadelphia, and London.

This monograph is one of the "Everyday Practice Series" edited by Harlow Brooks. It presents in a lucid but not in a highly technical style the disturbances of the gastrointestinal tract. Although functional disorders are emphasized primarily, consideration to such organic disturbances as ulcerative colitis are included apparently by way of contrast to make the volume more comprehensive and complete.

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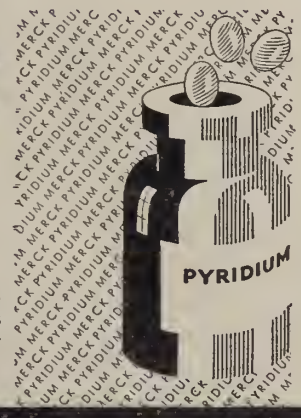

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Dr. Morgan considers first the physiology of the gastrointestinal tract and devotes a chapter to physical and laboratory examinations before proceeding to the consideration of the functional disturbances. Following a definition of the various disorders he discusses briefly the etiology, symptomatology, prognosis and treatment of the various disorders and with each condition presents enough case history to illustrate the disturbance.

The volume is especially valuable to the general practitioner and medical student more so than to the gastroenterological specialist. It is easily read and presupposes some knowledge on the part of the reader of the technique of laboratory procedures and special examinations for only mention is made of studies to be carried out rather than the detailed methods of procedure. In this regard it can not be considered as a manual.

The volume is handsomely bound in leather with a cover design reproduced from the noted "Summa Magistri" in 1499. The print in large, on a good quality of paper and the illustrations, which are well reproduced, are adequate but not profuse. An index facilitates the usefulness of the subject material. The wide experience of Dr. Morgan is reflected throughout in the presentation of a subject with which any office practitioner has daily contact.

Manual of Clinical and Laboratory Technic. By Hiram B. Weiss, A. B., M. D., associate professor of medicine, College of Medicine, University of Cincinnati; and Raphael Isaacs, A. M., M. D., associate professor of medicine, Assistant Director of Thomas Henry Simpson Memorial Institute for Medical Research, University of Michigan. Fourth edition, reset. 117 pages with diet table. Price $1.50 net. W. B. Saunders Company, Philadelphia.

This manual consists of four sections: An outline of a routine for the history and physical examination; the technic for laboratory tests; the technic for clinical procedures and a table of the composition of foods.

Its scope is limited to these, there is no discussion of the application or interpretation of the procedures given. This limitation precludes its use by students and practitioners. It should prove useful as an outline of work for internes, if adopted by a hospital as the standard routine.

It is of convenient pocket size, well bound, and the subject is presented lucidly. W. D. S.

Functional Disturbances of the Heart. By Harlow Brooks, M. D., attending physician, Fourth Medical Service, Bellevue Hospital; consulting physician, City Hospital, Montefiore Hospital, Beth Israel Hospital; St. Vincent's Hospital, Fifth Avenue Hospital. Price $5.00. J. B. Lippincott Co., Philadelphia and London.

This work by a distinguished clinician is one of the volumes of the "Everyday Practice Series", and is a record of the impressions and experiences of the writer. There is frankly no attempt to consider this difficult field from a critical viewpoint or to add to our knowledge of the physiological disturbances underlying the clinical states. Descriptions of methods and procedures are principally in the most general terms without effort at detail. The chapter on Neurocirculatory Asthenia is an exception to this as it is based on the published reports of the author and others derived from studies made during the World War. J. A. E. E.

Diabetes In Childhood And Adolescence. By Priscilla White, M. D., physician at the New England Deaconess Hospital, Boston. Price $3.75. Lea & Febiger, Philadelphia, 1932.

The problem of diabetes in childhood is presented in this monograph by means of an analysis of over 500 cases treated in the Joslin clinic at the New England Deaconess Hospital in Boston. The material is presented in a concise manner with abundant references at the end of each chapter.

The author discusses the etiology of diabetes at some length submitting proof that its familial nature follows the Mendelian law of simple recessives. A practical presentation of the physiology of metabolism is given. Emphasis is placed on the metabolism of fats with evidence to prove the rational of the Joslin method of treatment which includes a diet low in fat intake.

The principles of treatment are carefully presented with due emphasis for the handling of the many variable factors met with in children in computing diets and insulin dosages both in hospital and home practice. The diets of forty-five cases of controlled diabetes are given in chart form which include ages from five to fourteen years. The subject of coma is discussed in a separate chapter with mention of the errors commonly made in handling this complication.

The general make-up of the book with its bold-faced paragraph headings and concise presentation of material should make it valuable as a quick reference guide for physicians treating diabetes mellitus in children. C. E. R.

PRESS SERVICE

(Continued from page 805)

by sore throat are diphtheria, influenza, scarlet fever, and streptococcus sore throat, which is due to the same germ that causes blood poisoning and is liable to lead to severe complications, even to a fatal outcome.

"A sore throat is a danger signal. Do not neglect it."

* * *

MENTAL STRESS

Madison, Wis., Oct. 13.—There is no financial loss or other misfortune appalling enough to give any real cause for men to seek relief in suicide, according to the bulletin of the State Medical Society out today.

"There is no occasion for a man to drive himself to a mental breakdown or to the grave over the loss of a fortune," continues the bulletin, taking note of a tendency among some to become despondent over their financial losses.

PHYSICIANS' EXCHANGE

Advertisements for this column must be received by the 25th of the month preceding month of issue. A charge is made of $2.00 for the first appearance of copy occupying 1 inch or less of space and $1.00 for each succeeding insertion of the same copy. Kindly accompany copy with remittance to cover number of insertions desired. Advertisements from members of the State Medical Society will be accepted without charge. Such copy will be taken out after its second publication unless otherwise requested. Where numbers follow advertisements replies should be addressed care Wisconsin Medical Journal.

POSITION WANTED — Laboratory and x-ray technician, bookkeeper, with four years hospital and general office experience, desires position immediately. Capable of taking complete charge of office. Credentials furnished upon request. Miss Alma C. Arnold, 2225 N. 49th St., Milwaukee, Wis.

ASSOCIATION WANTED—Well trained pediatrician is available for group appointment or association with another specialist. Two years postgraduate study; two years private practice; age 31; unmarried; slight preference for midwest. References can be furnished regarding character and ability. Salary open. Address No. 895 in care of the Journal. ND

WANTED—Location for general practice in city of 5,000 or more with hospital. Address number 891 in care of the Journal. OND

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LOCATION AVAILABLE—Very good opportunity for one in general practice and ophthalmology, to locate in a well-to-do community in need of medical services. Address number 887 in care of the Journal. OND

DESIRABLE LOCATION for an experienced physician and surgeon in town of about seven thousand. Modern office, reasonable. In connection with dentist. For information write Box 296, Kaukauna, Wis. N

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WANTED—Good Wisconsin location for general practice. Address number 884 in care of the Journal. SON

FOR SALE—Retiring physician has following for sale: Allison table; Fairbanks office scale; Articulated skeleton; Plain cabinet; Large upholstered couch, storage beneath; Many office instruments and medical books. List on application. Address No. 894 in care of the Journal. ND

FOR SALE—Kelley-Koett motor driven tilt table; x-ray apparatus, 5" gap, 30 M. A.; x-ray filing cabinet; Brady-Potter bucky diaphragm, infra-red lamps; home model quartz lamps; cassettes and screens; Jones' basal metabolism apparatus, used four times. Will sell separately. Address C. J. Yeager, 4 S. Genesee St., Waukegan, Ill.

WANTED TO BUY SOON—Good established practice. Give complete details first letter. Address No. 892 in care of the Journal. OND

FOR SALE—Will sell for cash the following: Betz metal electric light bath cabinet, $50.00, cost $300.00; bacteriological incubator, $10.00, cost $35.00; massage table, $15.00, cost $65.00. Allison office table, $35.00, cost $75.00; operating table, $10.00; cystoscope, $25.00; Rochester case of electric diagnostic instruments, $15.00; Victor high frequency coil, No. 7, $25.00, cost $200.00; autocondension couch, $10.00; three Simmons hospital beds; 2 in. tubing; 50 lb. mattress, each $12.50, and one such bed with back rest, $15.00; or all four beds for $50.00; new Spencer microscope, three objectives, Alcoe Co., No. 84368, and bell jar, $60.00, cost $130.00; Israel Carmody suction apparatus for tonsil work, $50.00, cost $95.00; Victor lead protective screen, $25.00; one Coolidge X-Ray tube, medium focus, $20.00 and two 7 in. gas tubes, Green & Bauer, each $10.00; steel office safe, 26 in. high, $15.00, cost $45.00; Koster blood transfusion apparatus, $5.00; hand centrifuge for urinalysis, $1.50; human skeleton, French, articulated and cheap wooden cabinet, $35.00; Faught sphygmomanometer, $5.00; McIntosh No. 6 plate style "A" wall cabinet $15.00, cost $60.00, and McIntosh rectifier, $5.00, cost $25.00; two microtomes, each, $2.50; Von Fleischl's hamometer, $2.50, cost $24.00; Nicholas Senn operating table, $20.00; surgical instruments and splints at less than half of present price. Address number 883 in care of Journal.

WANTED—Office position by graduate nurse. Experienced for past two years in an EENT clinic. Can do typing and general office work. Address number 889 in care of the Journal. OND

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WANTED—General practitioner, pediatrician, eye, ear, nose and throat specialist and dentist. Address number 888 in care of the Journal. OND

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"In every active, ambitious person there arises a conflict between what he wants to do and what he is able to do—between desire and ability. He wants a large salary or a large income from his business; his earning power may not be above the average. He wants a position of high rank; he may lack the necessary qualifications or have no means of attaining it. He wants fine clothes, an expensive automobile, and a luxurious home; he may not have sufficient wealth to obtain any of these things. He wants a mate of exceptional beauty and charm; he may be able to find no one who meets his expectations. In these and in many other ways he fails to satisfy his instinctive longings.

"His attitude in face of these disappointments is a test of his real worth. If he adopts the unwholesome habit of blaming others for his lack of success; if he becomes sullen and angry at every rebuff; if he seeks consolation by telling a hard-luck story to anyone who will lend a sympathetic ear; if he loses interest in his work and in his personal appearance; if he indulges in worry or daydreaming; if he retaliates for fancied insults or injuries—if he does any of these things—he will not only fail to meet the test but render himself less able to satisfy other desires. He may even undermine his mental health.

"On the other hand, if he meets disappointment with renewed courage and vigor; if he puts the ideal of service above the hope of reward; if he places a moderate estimate on his ability and strives cheerfully for the good things within his reach, he will gain strength and may gradually attain a mastery of himself and of his field of work that will yield much personal satisfaction and win for him adequate material rewards and a large measure of social esteem."

* * *

DIPHTHERIA

Madison, Wis., Oct. 20.—The fight to check diphtheria among school children is being waged in Wisconsin this month through the cooperative efforts of the State Board of Health and the State Medical Society of Wisconsin. Warning that all school children should be given complete immunization against diphtheria was issued by the Medical Society this week as a cooperative effort with similar moves made by the State Board of Health.

Upwards of 50,000 children are born in Wisconsin annually, and the bulletin issued by the State Medical Society today advocates immunization of all children between the ages of nine months and twelve years.

"The diphtheria death toll in 1931 was the lowest in the history of Wisconsin totalling 54 out of 795 cases reported," declares the bulletin. "If this campaign can be continued, diphtheria can be thoroughly checked and eradicated in this state.

"Diphtheria has been and is essentially a disease of childhood. During the ages it has caused untold suffering and brought to an end countless young lives. Prior to 1890 no remedy based upon an understanding of the cause of the disease was known. From men working quietly in secluded laboratories came the announcement in 1885 that they had found and could always recognize the bacteria which cause diphtheria. This brought forth accurate methods of diagnosis. Soon after this discovery came the announcement that an antitoxin had been produced which, if administered early in the disease, would always cure. Prior to these discoveries, diphtheria was nearly always fatal. In 1881 over two thousand people died of diphtheria in Wisconsin.

"It is hard to have people believe that the results of scientific research can take the place of blind acts of sympathy and that men of science are not cold-blooded and inhuman. Many years were required to convince them that the use of diphtheria antitoxin could and would reduce by a large figure the death and suffering caused by diphtheria. However, its use became general and the total deaths in Wisconsin fell from two thousand and over in 1881 to fifty-four in 1931.

"During the last several years further studies have developed a method for preventing diphtheria. This like the antitoxin which is used only to cure the sick requires that the child be given an injection under the skin. This substance is called toxin-antitoxin. If the consent of all parents can be obtained for the administration of toxin-antitoxin, there will occur not only another spectacular fall in the number of deaths from diphtheria, but the disease will, in the course of a few years, be stamped out. The State Medical Society recommends that every parent see that his children receive this protection."

* * *

CONQUERING DIPHTHERIA

Madison, Wis., Oct. 27.—Wisconsin has waged war on diphtheria so successfuly that the annual death rate has decreased from 2,202 to 54, and a still further decrease is expected this year.

Some forty years ago diphtheria was one of the most dreaded and fatal diseases of childhood. Few homes in which there were children were spared, and the mortality was over fifty per cent.

This is the gist of a statement issued by the educational committee of the State Medical Society in a bulletin issued today. The bulletin declares that there were 80 deaths from diphtheria in 1929; 79 in 1930, and only 54 in 1931. This is one of the most successful campaigns that has been conducted against disease in Wisconsin.

"Not until 1908 was the reporting of sickness and death placed on a basis sufficiently complete to warrant Wisconsin's admission into the federal registration area," declares the bulletin. Such figures as are available, however, show clearly that until toxin-antitoxin came into use Wisconsin suffered bitterly from this scourge of childhood. In 1880, for example, when our population was about half of what it is now, 1,410 diphtheria deaths were recorded. In 1881 no less than 2,202 deaths were recorded.

"With the discovery of toxin-antitoxin in 1913, the death rate from diphtheria promptly fell, but even today many unprotected children still suffer with diphtheria and every day some child is apt to die of it. If your children have not been given toxin-antitoxin, they may be among the victims.

"Many thousands of fathers and mothers have made sure that their children will never take diphtheria, by having this inexpensive treatment to insure that their children need never fear the disease.

"Although fewer children are dying from diphtheria now than ever before, your child, if exposed to the disease, is in as much danger as he was before toxin-antitoxin was discovered, unless you have given him this protection.

"Most cases of diphtheria occur in children under five years of age. If children reach school age before being immunized it should certainly be done at once before the child enters school. All parents are urged by the State Board of Health to take advantage of this great life saving discovery and have their children immunized against diphtheria, thus protecting them from this disease throughout their childhood. The parent who knows that his child need never have diphtheria and then fails to secure that protection is carrying a heavy responsibility that few knowingly would wish to assume."

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RUPTURE OF GRAVID UTERUS

(Continued from page 784)

fects of morphine. The abdomen revealed two scars, one from a former high classical Caesarean slightly to the left of the mid-line, the other from a right rectus incision. The patient was extremely sensitive to abdominal palpation making this procedure difficult and of little value. Contractions could not be observed nor could the fetal heart be obtained. The blood pressure was 68–45, the pulse 80 and respirations 24, vaginal bleeding was present.

Laboratory findings showed a 4 plus albumin with many R. B. C.'s in the urine, the blood work revealed 3,630,000 R. B. C.'s and 18,000 W. B. C.'s per Cu. Mm. and the Hgb. was 85%.

A diagnosis of either a ruptured uterus or the frank type of accidental hemorrhage was made and it was decided to operate immediately. The patient was given an ampoule of adrenalin before operation. Ethylene being used as an anesthetic, a longitudinal incision approximately 7 inches long, slightly to the left of and centering at the umbilicus was made. On entering the peritoneal cavity the fetus and placenta were found in the free abdomen along with a large amount of blood and amniotic fluid. These were removed. At this time the patient's pulse was 180 the blood pressure 65–48 and respirations 42. Another ampoule of adrenalin was given and an infusion of 1000 cc. of 10% glucose was started. At first the uterus could not be located but it was finally found firmly contracted deep in the pelvis. The uterus was brought into view and due to the large extent of the rupture, which extended from the fundus of the uterus to the utero vesicular fold, repairing it was found impossible. A hysterectomy was done and the patient left the operating room in much better condition than when she had arrived. Blood pressure 130–80 pulse 120 and respirations 30. An hour later 200 cc. of whole blood was given. The patient had an uneventful recovery, having a slight elevation of temperature of 101 and 100–6–10, respectively on the second and third day. She left the hospital on the 14th postoperative day in good condition.

One Hundred Forty Licensed at June and September Meetings of State Board of Medical Examiners

BY RECIPROCITY

Name	School of Graduation	Year	Present Address
Atwood, David C.	Rush Medical College	1931	23 S. Pinckney St., Madison, Wis.
Bargholtz, Wm. E.	Iowa Medical Univ.	1931	Reeseville, Wis.
Bonner, Nelson A.	Kansas Medical Univ.	1931	Beaver Dam, Wis.
Cole, David F.	Wisconsin Medical Univ.	1931	317 Watson St.. Ripon, Wis.
Elliott, William	Rush Medical College	1927	Newark, Ill.
Goff, Sidney B.	Rush Medical College	1931	Elkhorn, Wisconsin
Kohl, Martha	Rush Medical College	1931	Oxford Court, Eau Claire, Wis.
Mannion, John E.	Creighton Medical Coll.	1920	Platte, South Dak.
Moore, Bert E.	Louisville Medical Univ.	1930	Mauston, Wisconsin
Patterson, Law. G.	Ohio Medical Univ.	1931	Scandinavia, Wisconsin
Prien, Edwin L.	Harvard Medical Univ.	1929	Memorial Institute, Madison, Wis.
Quick, Armand J.	Cornell Medical Univ.	1928	Theresa, Wis.
Ramlow, Leonard W.	Washington Medical Univ.	1930	Milwaukee Co. Hosp., Wauwatosa, Wis.
Robertson, Murl J.	Minnesota Medical Univ.	1931	Bayfield, Wis.
Schindler, John A.	Washington Medical Univ.	1931	New Glarus, Wis.
Smith, Herbert P.	Marquette Medical Univ.	1930	5400 Arsenal Ave., St. Louis, Mo.
Tjoflat, Oliver E.	Univ. of Wisconsin Med. Sch.	1929	5400 Arsenal Ave., St. Louis, Mo.
West, Lester Chas.	Chicago Coll. of M & S	1910	Trempeauleau, Wis.
Younker, Franklin T.	Northwestern Medical U.	1930	Galesville, Wis.
Bayer, Lester J.	Northwestern Medical Univ.		Merrill, Wis.
Cogger, Thomas W.	Loyola Medical University		3125 Palmer Sq., Chicago, Ill.
Eggers, Florence O.	Barnes Medical University		Baileys Harbor, Wis.
Eggers, Gustave C.	St. Louis College of P & S		Baileys Harbor, Wis.
Gantz, Hyman A.	Marquette Medical Univ.		Clarke Bldg., Waukesha, Wis.
Hill, Don Earl	Tennessee Medical Univ.		LaFarge, Wis.
Hudson, Edward D.	Virginia Medical Univ.		Lake Geneva, Wis.
Jeter, Marvin L.	Emory Medical University		Box B., Waupun, Wis.
Johnson, Herbert W. E.	Minnesota Medical Univ.		Richland Center, Wis.
Jones, Beatrice O.	Rush Medical University		707 Fullerton Ave., Chicago, Ill.
Krueger, Ernest N.	Minnesota Medical Univ.		213 No. Oneida St., Appleton, Wis.
Langford, Earl K.	Loyola Medical University		190 N. State St., Chicago, Ill.
Montgomery, Rob't P.	Michigan Medical Univ.		Wis. General Hosp., Madison, Wis.
Nuetzman, Arthur W.	Minnesota Med. University		810 26th Ave., N. E., Minneapolis, Minn.
Pierce, Michael J.	Illinois Medical Univ.		4003 Sheridan Road, Chicago, Ill.
Rovenstine, Emery A.	Indiana Medical Univ.		Wis. Gen. Hospital, Madison, Wis.
Shebesta, Emil M.	Univ. of Wisconsin Med. Sch.		Wis. Gen. Hospital, Madison, Wis.
Simonson, Sigvert	Minnesota Medical Univ.		Cameron, Wis.
Strong, Russel G.	Loyola Medical Univ.		1632 E. Irving Pl., Milwaukee, Wis.
Tasche, John A. Jr.	Cincinnati Medical Univ.		Sheboygan Clinic, Sheboygan, Wis.

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BY EXAMINATION

Name	School of Graduation	Year	Present Address
Ackerman, Emmett T.	Wisconsin Med. Univ.	1931	Gays Mills, Wisconsin
Akey, Harold Mark	Marquette Med. Univ.	1932	406 Third Street, Merrill, Wis.
Bachhuber, Alois M.	Northwestern Med. U.	1931	Mil. Co. Hospital, Wauwatosa, Wis.
Bachus, Arthur Carl	Marquette Medical U.	1932	Mil. Co. Hospital, Wauwatosa, Wis.
Baumann, Albert John	Marquette Medical U.	1932	3022 W. Rogers Street, Milwaukee, Wis.
Baxter, Harold L.	Colorado Med. Univ.	1931	412 High Street, Neenah, Wis.
Becker, Philip H.	Marquette Med. Univ.	1932	642½ Pine Street, Burlington, Wis.
Behnke, Edgar John	Creighton Med. Univ.	1931	2834 West North Ave., Milwaukee, Wis.
Belson, Harold J.	Marquette Med. Univ.	1932	917 No. 26th St., Milwaukee, Wis.
Bertolaet, Elmer E.	Wisconsin Med. Univ.	1931	327 Hudson St., Eau Claire, Wis.
Biller, James Harold	Marquette Med. Univ.	1932	2644 Kinnickinnic Ave., Milwaukee, Wis.
Blong, Theo. Edward	Marquette Med. Univ.	1931	230 W. Madison, St., Milwaukee, Wis.
Burdon, Thomas Sheldon	Wisconsin Med. Univ.	1931	1013 S. Jackson St., Green Bay, Wis.
Casey, James Donovan	Wisconsin Med. Univ.	1931	1555 Adams St., Madison, Wis.
Cheli, Clement F.	Wisconsin Med. Univ.	1931	426 W. Dayton St., Madison, Wis.
Clark, Owen Clifford	Wisconsin Med. Univ.	1931	Neillsville, Wis.
Clark, Wm. Elery	Harvard Medical Univ.	1931	Lakeside Hospital, Cleveland, O.
Darling, Sylvester J.	Columbia Medical Univ.	1931	1953 No. 34th St., Milwaukee, Wis.
Davies, May Alieen	Wisconsin Med. Univ.	1931	Mt. Horeb, Wisconsin
Dean, Joseph Chas.	Pennsylvania Med. Univ.	1930	626 E. Gorham St., Madison, Wis.
DeFazio, Stephan F.	Marquette Med. Univ.	1932	2756 No. 39th St., Milwaukee, Wis.
Denys, Glen F.	Marquette Med. Univ.	1932	231 Woodlawn Ave., Green Bay, Wis.
Enright, John A.	Marquette Med. Univ.	1932	2104 W. Highland Ave., Milwaukee, Wis.
Farness, O. Jocevious	Minnesota Med. Univ.	1931	Lakeview Sanatorium, Madison, Wis.
Feld, David	Marquette Med. Univ.	1932	3237 N. Oakland Ave., Milwaukee, Wis.
Frederick, Anthony J.	Marquette Med. Univ.	1932	519 School St., Columbus, Wis.
Frenn, Nathan Joseph	Marquette Med. Univ.	1932	1831 3rd Ave. No., Escanaba, Mich.
Frick, John Charlton	Wisconsin Med. Univ.	1931	1528 Vilas Ave., Madison, Wis.
Galasinski, Roman E.	Marquette Med. Univ.	1932	2483 S. 6th St., Milwaukee, Wis.
Garland, James Gillis	Marquette Med. Univ.	1932	Mil. County Hospital, Wauwatosa, Wis.
Gingrass, Rudolph P.	Marquette Med. Univ.	1932	R. 8, Box 310, Wauwatosa, Wis.
Glynn, James Douglas	Loyola Medical Univ.	1932	Potosi, Wisconsin
Goggins, John Rob't.	Marquette Med. Univ.	1932	Wisconsin Rapids, Wis.
Guzzetta, Vincent Jos.	Loyola Medical Univ.	1932	138 W. North Ave., Milwaukee, Wis.
Hahn, Anthony C. J.	Northwestern Med. U.	1931	813 Market St., Watertown, Wis.
Hamernick, Fred J.	Louisville Med. Univ.	1931	Hales Corners, Wis.
Hansen, Horace J.	Wisconsin Med. Univ.	1931	Milwaukee Co. Hosp., Wauwatosa, Wis.
Healy, Romeyn J.	Marquette Med. Univ.	1932	3098 So. Wentworth Ave., Milwaukee, Wisconsin
Houghton, John Henry	Marquette Med. Univ.	1932	2537 No. Prospect Ave., Milwaukee, Wis.
Houghton, Wm. John	Marquette Med. Univ.	1932	Milwaukee Co. Hosp., Wauwatosa, Wis.
Hughes, Byron James	Wisconsin Medical Univ.	1931	Pardeeville, Wis.
Hull, Harmon H.	Wisconsin Medical Univ.	1931	c/o W. H. Housley, M. D., Neillsville, Wis.
Huth, Edgar Wm.	Wisconsin Medical Univ.	1931	Crandon, Wis.
Jekel, Jerome M.	Marquette Medical Univ.	1932	1800 E. Capital Dr., Milwaukee, Wis.
Kingsburg, Charles H.	Marquette Medical Univ.	1932	1233 N. 31st St., Milwaukee, Wis.
Kleiss, Wm. Jack	Marquette Med. Univ.	1932	Milwaukee Children's Hosp., Milwaukee, Wis.
Kyhos, Emma D.	Wisconsin Med. Univ.	1931	304 Princeton Ave., Madison, Wis.
Leonard, Thomas A.	Wisconsin Med. Univ.	1931	1553 Adams St., Madison, Wis.
Litzen, Floyd L.	Wisconsin Med. Univ.	1931	Elcho, Wisconsin
Litzow, John Albert	Colorado Med. Univ.	1931	1229 So. 29th St., Milwaukee, Wis.
Lokvam, Leif Henry	Wisconsin Med. Univ.	1931	1309 59th St., Kenosha, Wis.
Malensek, Martin C.	Marquette Med. Univ.	1932	1210 So. 60th St., West Allis, Wis.
Marlewski, Cyril R.	Marquette Med. Univ.	1932	2957 So. Wentworth Ave., Milwaukee, Wis.
Martens, Earl Wm.	Marquette Med. Univ.	1932	Milwaukee Co. Hosp., Wauwatosa, Wis.
Martins, Ronald F.	Wisconsin Med. Univ.	1932	Wis. General Hosp., Madison, Wis.
Mastalir, Lester O.	Marquette Med. Univ.	1932	538 Jefferson St., Burlington, Wis.
Mauthe, Walter	Marquette Med. Univ.	1932	832 No. 22nd St., Milwaukee, Wis.
McQuine, Harold J.	Marquette Med. Univ.	1932	1204 W. Wis. Ave., Milwaukee, Wis.
Meili, Emmett A.	Wisconsin Med. Univ.	1931	Cochrane, Wisconsin
Moglowsky, Simon	Marquette Med. Univ.	1932	1737 N. 10th St., Milwaukee, Wis.
Monroe, Maurice E.	Northwestern Med. Univ.	1932	Hartford, Wis.
Morrison, Russell C.	Wisconsin Med. Univ.	1931	1253 Williamson St., Madison, Wis.
Morrow, Cecil A.	Rush Medical Univ.	1931	2318 75th St., Kenosha, Wis.
Nichols, Chas. Henry	Northwestern Med. Univ.	1932	6647 Ingleside Ave., Chicago, Illinois
Niebuhr, Wm. August	Wisconsin Med. Univ.	1931	16 South Henry St., Madison, Wis.
Nieweczas, Michael S.	Marquette Med. Univ.	1932	Milwaukee Co. Hosp., Wauwatosa, Wis.
O'Brien, Paul T.	Marquette Med. Univ.	1932	2002 W. Juneau Ave., Milwaukee, Wis.
Overgard, Albon Wm.	Wisconsin Med. Univ.	1931	Stanley, Wisconsin
Pallasch, Frank J.	Marquette Medical Univ.	1932	2428 N. Humboldt Ave., Milwaukee, Wis.
Passalacqua, Cosmo	Marquette Medical Univ.	1932	9531 Farragut Road, Brooklyn, New York
Pederson, Allen Jesse	Northwestern Medical U.	1932	848 N. 24th St., Milwaukee, Wis.
Pinegar, Kenneth Geo.	Northwestern Med. Univ.	1932	Marinette, Wis.

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Name	School of Graduation	Year	Present Address
Pomainville, Leland C.	Wisconsin Medical Univ.	1931	Milwaukee Co. Hosp., Wauwatosa, Wis.
Quisling, Gunnar D.	Illinois Medical Univ.	1932	421 N. Patterson St., Madison, Wis.
Quisling, Rolf A.	Illinois Medical Univ.	1932	421 N. Patterson St., Madison, Wis.
Rice, Maurice Greg.	Marquette Med. Univ.	1932	Milwaukee Co. Hosp., Wauwatosa, Wis.
Rogers, Raymond J.	Marquette Med. Univ.	1932	1539 So. 71st St., West Allis, Wis.
Ronneburger, Ernest O.	Marquette Med. Univ.	1932	138 W. Chambers St., Milwaukee, Wis.
Ryan, James L.	Marquette Med. Univ.	1932	Blanchardville, Wis.
Schwartz, Geo. Rob't.	Marquette Med. Univ.	1932	2143 N. 33rd St., Milwaukee, Wis.
Shields, Gregory G.	Marquette Med. Univ.	1932	Abbotsford, Wis.
Slaybaugh, James C.	Marquette Med. Univ.	1932	927 No. 17th St., Milwaukee, Wis.
Slutzky, Nathan	Wisconsin Med. Univ.	1931	2142 No. 16th St., Milwaukee, Wis.
Smith, Russell C.	Wisconsin Med. Univ.	1931	c/o Judge Comstock, Barron, Wis.
Stehr, Arthur Carl	Wisconsin Med. Univ.	1931	503 State St., Madison, Wis.
Sullivan, James M.	Marquette Med. Univ.	1931	703 E. Juneau Ave., Milwaukee, Wis.
Tarachow, Sidney	Marquette Med. Univ.	1932	N. Y. State Psychiatric Inst., New York City, N. Y.
Thomas, Norman G.	Wisconsin Med. Univ.	1931	Cobb, Wisconsin
Torcivia, Santo S.	Marquette Med. Univ.	1932	335 No. Jefferson St., Milwaukee, Wis.
Treskow, Frank G.	Wisconsin Med. Univ.	1931	2105 Oakridge Ave., Madison, Wis.
Wall, Willard Wm.	Wisconsin Med. Univ.	1931	Middle River Sanatorium, Hawthorne, Wisconsin
Werner, David J.	Marquette Med. Univ.	1932	Mil. Co. Hospital, Wauwatosa, Wis.
Wilets, Jack Charles	Marquette Med. Univ.	1932	832 W. Clybourn St., Milwaukee, Wis.
Barrock, James J.	Marquette Medical Univ.		2436 W. State St., Milwaukee, Wis.
Bonifer, Philip P.	Marquette Medical Univ.		Nichols Mem. Hosp., Battle Creek, Mich.
Feldman, Harry	Wisconsin Medical Univ.		1314 St. James Court, Madison, Wis.
Kovacs, Madeleine	Peter Pazmary University of Royal Hungarian, Budapest		4182 Plankinton Bldg., Milwaukee, Wis.
Radl, Cyril J.	Marquette Medical Univ.		Sleepy Eye, Minn.
Schoenecker, Edgar A.	Illinois Medical University		2505 N. 11th St., Milwaukee, Wis.
Van Ess, Jerome R.	Marquette Medical Univ.		N. Y. Polyclinic, W. 50th St., New York City, New York
Watry, Theodore D.	Marquette Medical Univ.		Sta. D. R. 1. Box 864, Milwaukee, Wis.

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MEDICAL ECONOMICS IN WISCONSIN

Every member of the State Medical Society of Wisconsin appreciates that the future of *his* practice, as well as those who are to follow, is in a stage of flux. None, then, can afford not to be thoroughly versed in the special committee reports to be found in the supplement to this issue, nor in the findings of the Committee on the Costs of Medical Care, the J. A. M. A. editorial on that subject, and the threatened lay control of practice in Wisconsin as reported in the President's Page and a special article in this section. This issue, above all others, is deserving of unhurried and careful reading.

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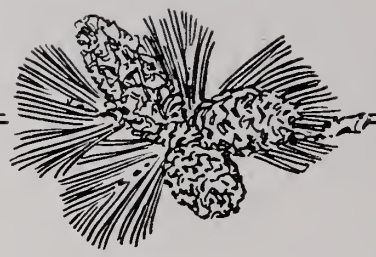

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Transphrenic Infection*

By HOWARD L. BEYE, M. D.
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Iowa City, Iowa

An infection in the extreme upper portion of the abdominal cavity has a marked tendency to become thoroughly localized to form an abscess. The diaphragm forms the roof of the abscess.

Probably eighty percent of such subphrenic infections follow the perforation of a peptic ulcer or an acute attack of appendicitis with general peritoneal contamination. About two-thirds of the abscesses are situated on the right between liver and diaphragm and the remaining third lie on the left between stomach, splenic flexure, left lobe of the liver, spleen, and diaphragm.

The infecting organisms are varied, but streptococci and the colon bacillus predominate and mixed infections are common.

An infection localized around the kidney is in reality a form of subphrenic abscess. The great majority of such infections undoubtedly take place via the blood stream through the capsule of the kidney, and when situated around the upper pole of that organ the abscess is commonly bounded above by the diaphragm.

The infecting organism in perinephric infections is the staphylococcus aureus in about seventy-five percent of the cases. When such an abscess is the result of appendicitis with ascending retroperitoneal infection the infecting organism is likely to be the colon bacillus or a streptococcus.

When an infection localizes under the diaphragm in either the intra-abdominal or perinephric situation, the diaphragm usually rises to its level of complete expiration and becomes immobile, and it is in this position that the abscess forms under it.

The diaphragm is traversed by a rich network of lymphatic vessels which feed into collecting nodes situated upon its upper surface and immediately under the pleura which lines the diaphragm. The lymph flow is from below up.

Any infection under the diaphragm, whether of the intra-abdominal or perinephric variety, may produce an inflammatory reaction within the thoracic cavity varying considerably in extent and degree. The two factors which are significant in respect to this are, first, the lymphatic drainage through the diaphragm and, second, the fixation of the diaphragm.

An infection situated on the right between the liver and diaphragm is especially likely to produce an inflammation of the thorax because of the great area of diaphragm surface which is commonly involved and because the liver acts as an efficient barrier to extension of the process downward. A perinephric abscess is much less likely to pass the barrier of the diaphragm because its contact with the diaphragm is often extremely limited and an abscess situated around the kidney can extend its boundaries into the flank. The nature of the infecting organism in any case is also of considerable import. The streptococcus is relatively much more likely to pass through the diaphragm than any other.

The nature of the inflammatory process above the diaphragm is extremely variable. In its simplest form it is manifested by a fibrinous pleuritis which tends to fix the base of the lung to the diaphragm. It may be manifested clinically by "pleurisy pains" and the finding of a friction rub. A roentgenological examination reveals an immobile diaphragm and a "fuzzy" outline of its upper surface.

A serous effusion may be present in the thorax. This may develop insidiously over

* Presented before 90th Anniversary Meeting, State Medical Society of Wisconsin, Madison. Revised to publication date.

a period of many days but occasionally is of sudden onset and of very great amount in twelve to twenty-four hours. It may be sterile. It may contain organisms which can be demonstrated on smear but not in culture, indicating the protective nature of the exudate. It may contain virulent bacteria.

A frank empyema is the commonest clinical manifestation of infection above the diaphragm. It is usually well localized just above the subphrenic abscess. It frequently will be loculated and the fibrinous bands which stretch from the diaphragm to the surface of the compressed lung are the evidence that a plastic pleuritis preceded the gross infection. An empyema may be complete.

Pneumonitis of some degree is nearly as frequent as empyema. It varies from a simple consolidation of the area immediately above the diaphragm—usually a roentgenological finding—to gross abscess. The latter condition may, in reality, be the manifestation of a diaphragmatic empyema which has burrowed into the lung parenchyma. Establishment of drainage into the bronchial tree is usual.

Because of the initial obliterative pleuritis involving the pleural surfaces of the lung and diaphragm which so commonly precedes actual infection of the thoracic cavity, there may be a complicated pathological picture produced. The lung may remain tightly adherent to the diaphragm in part and become grossly infected, and an associated empyema or pleurisy with effusion may occupy another portion of the thoracic cavity.

Extension of infection through the diaphragm to the thorax is probably via the lymphatics in the early stages but in a surprisingly large number of cases the diaphragm later becomes grossly damaged with the development of a perforation of it so that a direct communication is present between the subphrenic abscess and the lesion in the thorax. This is often large enough to admit one's finger. In exceptional instances there will be multiple perforations of the diaphragm.

The symptoms associated with extension of infection from a subphrenic abscess to the thoracic cavity vary considerably. They often develop insidiously. They will sometimes be the first diagnostic manifestation of a subphrenic abscess. They not uncommonly dominate the clinical picture, and the lesion below the diaphragm is entirely overlooked.

Following an operation for suppurative appendicitis with perforation, the symptoms of intrathoracic complication are frequently considered to be a postoperative pneumonia, and the presence of a subphrenic abscess is not thought of. An unsuspected chronic subphrenic abscess is especially likely to attract medical attention because of symptoms referable to the thorax and such patients are often treated for pulmonary tuberculosis or bronchiectasis.

The diagnosis of the thoracic complication of subphrenic abscess must include the recognition of the latter. A very careful history is essential with the possibility of the presence of a subphrenic abscess kept in mind. A subphrenic abscess—especially one localized between liver and diaphragm on the right—is seldom stumbled upon by diagnostic accident.

Competent roentgenological examination is usually necessary and must often be repeated to determine the changes in the thoracic picture as they develop. Lateral fluoroscopy and films should be included as a routine.

The treatment of the thoracic involvement from subphrenic abscess must necessarily vary with the character of the complication. The subphrenic abscess must usually be drained independently.

A pleural effusion even if it contains viable organisms will commonly be absorbed, and often quite rapidly, following drainage of the subdiaphragmatic infection. A frank empyema should be drained. A gross infection of the lung parenchyma is a very serious matter but it will oftentimes clear up following drainage of the subphrenic abscess if there is a gross break in the diaphragm so that the pulmonary abscess is drained indirectly.

In conclusion it should be emphasized that a thoracic infection will occasionally be first manifested *after* the drainage of a subphrenic abscess and where the operative procedure has in no way injured the diaphragm

or pleura. This is undoubtedly due to the change in tension of the diaphragm so that it falls away from the adherent lung and thus lights up a localized infectious process which had developed and was slumbering.

SUMMARY

An infection situated along the under surface of the diaphragm may transverse the latter to produce an inflammation within the thoracic cavity.

Extension of infection may be via the lymphatics or by direct extension through a gross break in the diaphragm.

The signs and symptoms referable to the thoracic pathology may greatly overshadow those of the infraphrenic infection. This is especially likely in chronic cases.

Punch Prostatectomy*

By HERMON C. BUMPUS, JR., M. D.
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Following the first successful prostatectomy at the beginning of this century, a goodly number of men past middle age have sacrificed a part of their anatomy as a ransom for freedom of urination. The price of such freedom has become so universally accepted by patient and physician that the logical idea of removing only the portion of the gland which is causing the obstruction has received indifferent attention. It should be remembered, however, that as early as 1877 the Italian surgeon Bottini suggested the possibility of such removal and developed an instrument for destroying the obstructing portion of the gland by means of cautery. In the beginning of the present century Freudenberg of Berlin added to the Bottini idea the aid of the cystoscope, a combination that was also developed by Chetwood in America during the same period. These instruments left much to be desired with regard to accuracy of technic, and they soon fell into disfavor. The logic of removing only the obstructing portion of the gland was not lost sight of entirely, and in 1911 Young presented his punch instrument, which consisted of an endoscopic tube with an opening near the end into which the obstructing tissue protruded and was removed by the sharpened end of an inner sheath. This instrument, however, was designed for the relief of obstruction of the neck of the bladder that resulted from cicatricial contracture from long-continued chronic infection, as was a similar instrument presented by Braasch and called a median bar excisor. A warning was given against the use of these instruments in cases of senile adenomatous hypertrophy, and as adequate provision for hemostasis was not provided, the extensive removal of tissue was not possible.

In 1921 Caulk adapted a cautery blade to the Young instrument and urged physicians to remove tissue more extensively. Although the added feature of the cautery blade reduced hemorrhage and enabled the operator to remove more tissue, the disadvantage of insufficient vision that is usual in an endoscopic tube with a closed end persisted, and if a cautery blade was used for cutting, visualization during the operation was impossible and postoperative sloughing and infection were distressing.

Since it was possible to remove tissue under vision with the instrument devised by Braasch, I undertook, in 1926, to remove appreciable amounts of tissue in cases of urinary obstruction that resulted from adenofibromatous hypertrophy. Since then 212 patients have been operated on, including thirteen with carcinoma and one tuberculosis of the prostate gland. The hemorrhage was controlled by electrocoagulation of the cut surface with a Bugbee electrode through a direct cystoscope. The punch instrument has since been modified to carry this electrode.

I have recently received replies from many of these patients, from all of whom a considerable amount of adenofibromatous tissue was removed in 1926 and in 1927.

A man, aged fifty-two years, who had been found to have 480 c.c. of residual urine in October, 1926,

* Presented before 90th Anniversary Meeting, State Medical Society of Wisconsin, Madison. Revised to publication date.

wrote: "Passing urine all right since leaving the hospital. Everything seems to be working very fine."

A man, aged fifty-four years, who had 250 c.c. of residual urine in November, 1926, and from whom I removed 8 gm. of obstructing prostatic tissue, wrote: "It has been four years since I was operated on and have had no trouble whatever."

A man, aged fifty-four years, had had 150 c.c. of residual urine in September, 1926. Four good sized pieces of adenofibromatous tissue were removed by the punch. The patient wrote: "Ever since this operation a large stream passes freely and without interruption. Urination presents no difficulties."

A man, aged fifty-five years, had 90 c.c. of residual urine. Four years later he wrote: "Have had no difficulty since operation; get up but once at night and sometimes not at all."

A man, aged seventy years, had 250 c.c. of residual urine. A punch operation was performed in August, 1927. The patient wrote four years later as follows: "I have no difficulty in passing my urine. I sleep all night without urinating."

A man, aged seventy-one years, had complete urinary retention. I removed the obstructing portion of the prostate gland in June, 1927, and this year he wrote: "The urine has passed perfectly ever since leaving the hospital more than four years ago."

I reported this method of controlling hemorrhage after the removal of considerable tissue in 1926 but, of course, sufficient time had not then elapsed to draw definite conclusions as to the final results.

In 1928, Stern of New York developed a lens instrument by means of which portions of the prostate gland could be removed under vision; cutting in this case by a very high frequency current of low voltage reduced hemorrhage appreciably. This instrument, called the prostatic resectoscope, has been recently modified by Davis of South Carolina so that a coagulating current can also be employed to control the more obstinate bleeding from the larger vessels in the manner I employ following knife excision with Braasch's instrument.

The technic and instruments employed matter little if sufficient obstructing prostatic tissue is removed to relieve the patient of all residual urine without excessive bleeding, either immediate or delayed. That this is possible in a far greater number of cases than is generally realized, I believe will be proved in the years to come. The operation is simple, the risk is minimal and the final results are equal, if not superior, to those

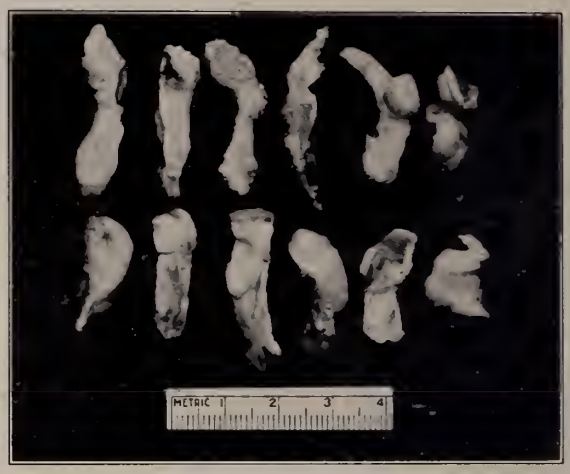

Fig. I. Pieces of prostatic tissue removed by means of punch from a patient with adenomatous hypertrophy.

following complete removal of the gland. The success or failure of the method depends largely on a single factor, the operator's ability to remove sufficient tissue so that an adequate channel may form from the trigone to the verumontanum. If this is done the bladder will empty. In the absence of residual urine, the remainder of the gland shrinks rapidly, infection subsides, and even dysuria and frequency disappear.

DECREASE IN SIZE

All urologists know, and I suspect most observant physicians have noted, that following suprapubic drainage of a bladder distended by the obstruction of an enlarged prostate gland, the size of the gland invariably diminishes. In fact, this diminution is one of the important reasons for the operation in two stages in cases in which operation is a risk. The removal of the gland after acute congestion and infection have subsided is not so likely to be accompanied by, or followed by severe hemorrhage.

Since the prostate gland decreases in size with removal of residual urine, it is apparent that the same shrinkage will occur whether the urine runs out of a suprapubic tube or is passed by the patient through the urethra, made once more adequate in size by removal of whatever portion of the gland impinges on its lumen (fig. 1). When this can be accomplished by intraurethral manipulation, all indications for prostatectomy vanish, for

few men will sacrifice the prostate gland while they can empty the bladder.

If, however, sufficient tissue is not removed completely to abolish residual urine, the wound will not heal readily but will serve, with adjacent traumatized tissue, as a focus of infection throughout the urinary tract. Secondary pyelitis and cystitis inevitably follow and relief is obtained finally only by suprapubic drainage and prostatectomy.

Of the four deaths in this series, two were directly attributable to infection following failure to remove sufficient tissue completely to relieve residual urine, another death was due to embolus, and the remaining death was that of a debilitated man aged seventy-three years, with extensive malignancy of the prostate gland.

This fact makes it imperative to select proper cases for this method of treatment. Such selection should not be made because of the fact that renal insufficiency or cardiac injury makes the risk of prostatectomy too great, but rather, the choices should depend entirely on the amount of prostatic tissue which must be removed to make possible complete emptying of the bladder. In most cases, probably, if examination is made when symptoms first develop, the amount of tissue demanding removal to relieve obstruction will not be found excessive.

In the cases in which I have operated by this method, 15 gm. of tissue is the greatest amount I have ever been compelled to remove, and many of my patients have come to the clinic with complete urinary retention. I do not feel, therefore, that the amount of residual urine is any criterion as to the possibility of relief from this procedure. In a number of cases the obstruction had been present so long that the resulting renal injury made suprapubic drainage advisable before even partial removal of the gland was undertaken, but such cases are in the minority.

Urologic surgeons now generally agree that as a result of the accuracy of modern tests of renal function, impaired renal function no longer plays the leading part in the mortality rate. Likewise, the heart is so carefully observed that its ability to withstand major surgical procedures can be well gauged. The third great complication of prostatectomy, namely, hemorrhage, has also been fairly well controlled by the use of the hemostatic bag. But an unsolved problem is the presence of sepsis, the prostatic bed with its venous plexus being a veritable sponge for the absorption of any and all pathogenic organisms.

All punch resections of the prostate gland for benign hypertrophy performed from January 1, to August 1, 1931, in all of which, except case 27, residual urine entirely disappeared after the operation

Case	Age, years	Residual urine at registration, c. c.	Days in hospital following operation	Weight of tissue removed, gm.
1	68	420	61	9
2	58	120	9	11
3	63	60	24	10
4	51	20	5	4
5	51	30	12	9
6	58	120	21	3
7	65	75	7	9
8	47	450	22	3
9	54	30	11	8
10	50	60	6	2
11	65	300*	16	7
12	48	300*	28	5
13	61	100	5	5
14	47	100	5	2
15	62	45	8	8
16	38	150	6	2
17	50	40	8	5
18	73	150	6	2
19	60	60	3	2
20	41	90	4	1
21	55	150	4	1
22	61	----------	9	2
23	60	20	11	2
24	56	150	8	1
25	66	90	6	9
26	63	55	19	8
27	65	300*	Died	5
28	58	110	6	5
29	63	70	7	3
30	73	60	14	4
31	69	100	10	1
Average	58.29	128.22	12.03	4.77

*No urine of the indicated patients was passed without catheterization. Therefore, all of it was considered to be residual, and the quantity was estimated at 300 c.c.

HEMORRHAGE OVERCOME

The complication of hemorrhage in modern punch operations, because of the technic employed, is overcome as the hemorrhage following the removal of tissue is controlled by electrocoagulation, thus, the lymphatics

as well as the blood vessels are sealed and postoperative fevers are the exception, all of which has an important economic bearing. Uncomplicated prostatectomy usually requires a minimal stay of six weeks in the hospital from examination to dismissal; the patient undergoing a punch operation usually leaves the hospital on the fourth to the seventh day. A certain amount of postoperative prostatitis and cystitis still remains for treatment, but the patient is ambulatory and if residual urine is not present the symptoms of these rapidly disappear.

So far this year, at The Mayo Clinic all but one of the patients from whom prostatic tissue was removed as the initial procedure were free of residual urine at the time of dismissal. The one patient who was an exception to this statement died (tabulation). When it is recalled that it takes several weeks for the edema and prostatitis incident to the operation to subside, the adequacy of the new urethral channel produced by the punch operation is apparent, for in more than a third of the cases more than 100 c.c. of residual urine was present before operation, and in three cases retention was complete at time of registration.

The question of the necessity of subsequent prostatectomy is always brought forward when the punch operation is mentioned. Many surgeons with theoretical minds refuse to believe that the removed tissue will not be rapidly replaced. In nine of this series of 212 cases (4.24 per cent) subsequent prostatectomy has been necessary. In six cases it was appreciated while the patient was still in the hospital that removal of larger amounts of tissue would be necessary and prostatectomy was done before the patient was dismissed. In three other cases the obstruction developed later; in one case, three months, in one, three years, and in one, four years after the punch operation. I think recurrence in this proportion of 1.41 per cent may be expected, and should not be considered as a contraindication to the operation. During the present year I have observed two cases of recurrent prostatic hypertrophy following complete prostatectomy, and a report of a series of such cases observed by Cunningham has recently appeared in the urologic literature. The complication, therefore, is not peculiar to the punch operation.

If results following prostatectomy were functionally good in all cases, the mortality, even though it is higher than for any other operation on benign lesions, would be justified. It is regrettable, however, that many of these aged patients are not completely relieved of symptoms by prostatectomy, or that other symptoms develop following the great surgical risk they have taken. A urologist of a neighboring university hospital informed me recently that at one time last winter 25 per cent of his prostatic cases referred from throughout his state, were made up of dysfunction occurring late after operation.

A procedure that can correct this condition and at the same time lower the mortality deserves, I believe, the support of the entire profession.

Renal Tuberculosis In Children*

By WALTER M. KEARNS, M. D., and
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Renal tuberculosis in children is uncommon according to the reports of urologists. Beer (1) encountered only one case under the age of 10 years in a series of 280 cases. Wildboltz (2) reported only 4 cases between the ages of 1 to 10 years in a series of 316 cases. Stevens (3) in a review of 1082 cases in the literature found among them only 6 cases in children under 11 years of age. The combined cases reported by these observers total 1678 and include only 11 cases in children, or six-tenths of one per cent. More recently Falci (4) in a series of 651 cases found 12.12 per cent in children under 10 years of age. He found that the majority of workers agree that tuberculosis of the urinary tract in early childhood is

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much more frequently bilateral than in the adult and that the younger the child the more frequent the bilateral involvement. The progress in the bilateral cases in children is rapidly fatal. The operative result in unilateral cases is poor, 24 per cent being successful in his series as compared to 56 per cent in the adult. Falci quotes Broca, who, in counterdistinction to his own observations, claims that the results of nephrectomy in children are favorable. This presupposes that there exists a healthy condition of the lungs and the remaining kidney which Falci believes rarely to exist. Myers (5) believes that the incidence of renal involvement among tuberculous children is very high and states that some observers place it as high as 23 per cent. M. G. Peterman (6) of Milwaukee Children's Hospital, in a series of 29 necropsies on children with generalized miliary tuberculosis encountered during the past 6 years, found 10 showing renal involvement. This high incident of renal involvement takes place as part of a disseminating process which occurs more frequently in children. This class of patients is seldom seen by the urologist. In the adult renal tuberculosis much more frequently represents an isolated focus of active infection.

The details of an urologic study in children have been well discussed in the contributions of Helmholz, Stevens (3), Kretschmer (7), Campbell (8) and in the recent excellent monograph of Beer and Hyman (1). The indications and contraindications for a cystoscopic examination in the young are similar to those of the adult.

With the application of all modern urologic methods to the examination of juveniles, more surgical chronic renal tuberculosis will be found and reported.

DIAGNOSIS

A suspicion of renal tuberculosis should be entertained when pyuria and ardor persist in spite of well planned medical treatment. Pyuria in the absence of pathogenic organisms, so-called sterile pyuria, almost invariably means tuberculosis. Albuminuria and acidity are constantly present, while hematuria is a frequent accompaniment.

The diagnosis of renal tuberculosis rests upon the finding of tubercle bacilli in the bladder urine. While a prolonged and careful search is frequently required the result is positive in practically every instance. Tuberculosis is a bacterial disease and the logical proof of its existence is the bacteriological finding. This point can not be too strongly stressed since there is a widespread tendency to neglect the bacterial search and substitute pyelography which is, at best, a relative method. The routine use of retrograde pyelography has been condemned by one (9) of us on the grounds of its needlessness, unreliability and danger. More recently Wildboltz (10), B. A. Thomas (11), Beer (1) and Campbell (12) have declared their opposition to the method.

When the presence of urinary tuberculosis has been demonstrated, cystoscopy, ureter catheterization, and kidney function tests complete the diagnosis by revealing the extent and location of the process. In the past twenty years the gradual improvement by Nitze, Wolf and others in Europe, Brown, Buerger, Beer, Butterfield, Corbus and others, with the assistance of the Wapplers, in this country, has resulted in the perfection of small instruments suitable for cystoscopy and ureter catheterization in infants of both sexes. The French Corbus children's cystoscope size number eleven has been used by us with satisfaction in boys at the age of four years.

PATHOLOGIC PROCESS

The pathologic process of renal tuberculosis in children is similar to that found in adults. B. A. Thomas (11) distinguished seven anatomicopathological types: tuberculous nephritis, acute miliary tuberculosis, chronic miliary infiltrating tuberculosis, ulcerative tuberculous papillitis, tuberculous pyelitis, caseo-cavernous tuberculosis and tuberculous pyonephrosis. The advanced cavernous and pyonephrotic types of lesions are the most commonly encountered in children because many of them are operated upon for a palpable mass in the kidney region, the nature of which is disclosed by the pathologist. The earlier lesions, such as tuberculous papillitis, are seldom encountered

because of the usual lack of proper early study.

When the disease is unilateral, nephrectomy is the proper treatment provided no contraindications exist. In preparation for operation a short period of rest, diet regulation, and blood transfusion in certain patients are most important factors in preventing dissemination of the disease or activation of old lesions. The post-operative treatment extends usually over a long period of time and is best carried out in a sanatorium where there is a strict adherence to hygienic routine. In bilateral disease, palliative measures with special reference to the distressing bladder symptoms are carried out.

CASE REPORTS

During the past year at Muirdale, Milwaukee County Sanatorium for the treatment of tuberculosis, among a colony of 65 children there were found three children with renal tuberculosis.

CASE 1. L. C., a four year old white boy was admitted to Muirdale Sanatorium on June 30, 1928, because of a persistent cough which began one year previously following tonsillectomy and adenoidectomy. His past history included measles when he was 2 months old and again at the age of two years; pneumonia at 5 months, 7 months and at 2 years; scarlet fever at 2 years of age; chicken pox when he was 3 years old. The only pertinent point in the physical examination was the enlargement of the posterior cervical glands. The urinalysis and the blood count were normal. The blood Wassermann and Kahn tests were negative. A stereoscopic x-ray film of the chest showed infiltration of both lungs.

In October, 1928, three months after admission, his urine showed a trace of albumin, occasional granular and hyaline casts and a few leucocytes. A persistent search for tubercle bacilli in the sediment was unsuccessful until Oct. 17, 1929, when the organisms were found.

Cystoscopy was carried out under intravenous sodium amytal anaesthesia. Edema was present about the left ureteral orifice. A number 3 French ureteral catheter passed unobstructedly into the right ureter for 20 cm. while the same sized catheter met an obstruction 1 cm. from the left ureteral orifice. The urine from the right kidney was alkaline in reaction and neither tubercle bacilli nor leucocytes could be found in the sediment. The bladder urine was acid in reaction, showed a trace of albumin, the sediment revealed leucocytes, an occasional erythrocyte and tubercle bacilli. Urography was carried out by the intravenous injection of 45 c.c. of 20 per cent iopax solution. A circumscribed dilatation and moth eaten outline was faintly visible in the upper calyx of the left kidney. A diagnosis of left renal tuberculosis was made. In view of the complete arrest of his pulmonary activity left nephrectomy was advised. The parents refused permission. The patient left the city.

Case #2, Fig. 1. Intravenous urography showing dilatation and ragged outline of the right kidney pelvis and calices especially in the lower one. The right ureter is markedly dilated and tortuous. The left renal pelvis shows a normal filling.

CASE 2. T. M., a Mexican boy 4 years old was admitted to Muirdale Sanatorium on Jan. 6, 1931, for observation because of contact with pulmonary tuberculosis in his family. The urinalysis on admission revealed an acid reaction, a trace of albumin and erythrocytes and leucocytes in the sediment. On Jan. 31, 1931, tubercle bacilli were demonstrated in the urinary sediment.

A cystoscopy performed on Feb. 26, 1931, showed a generalized cystitis. A greater degree of hyperemia was evident about the right ureteral orifice. On this side a number 3 French ureteral catheter encountered an obstruction 3 cm. from the bladder wall. A number 4 French ureteral catheter was passed easily 15 cm. to the left kidney pelvis. The urine from the right kidney was acid in reaction, showed albumin, many leucocytes and tubercle bacilli were present in the sediment. The urine from the left kidney was normal. One cubic centimeter of phenolsulphonphthalein injected intravenously resulted in an excretion of 13 per cent in 7 c.c. of urine on the right side and 20 per cent in 9 c.c. of urine on the left side during a 15 minute test. The urea concentration in the urine from the right side

was 0.03 of 1 per cent while that of the left side was 0.04 of 1 per cent.

Urography after the intravenous injection of 45 c.c. of 20 per cent iopax solution showed much dilatation of the ureter and pelvis of the right kidney in contrast to a normal outline on the opposite side. A diagnosis of tuberculosis of the right kidney was made and right nephrectomy was advised but refused. This patient was removed from Muirdale Sanatorium.

Through the excellent work of a social worker our patient was sent to the Milwaukee Children's Hospital. Through the courtesy of Dr. M. G. Peterman and Dr. N. W. Bourne, the attending urologist, we were permitted to continue our examination and treatment of this boy. Intravenous urography and cystoscopy were repeated with confirmatory results. A right nephrectomy was insisted upon and was performed on June 8, 1931. On sectioning the removed kidney a small circumscribed ulceration in the papillae of the lower pole communicating with the pelvis was observed. A smear made from the ulcerative material showed an abundance of tubercle bacilli in the Ziehl–Neelsen stain. Recovery has been quite uneventful.

CASE 3. I. M., a white boy 7 years old was admitted to Muirdale Sanatorium on June 27, 1930, because of a sudden onset of frequency, dysuria and total hematuria 3 months prior to admission. The past medical history was insignificant except for indefinite pain in the right kidney region at the age of 2 or 3. There was no history of exposure to tuberculosis. The physical examination revealed a pale, poorly nourished boy with several carious teeth. There was tenderness to light palpation in the suprapubic area. The urine was acid in reaction, contained a heavy trace of albumin, and the sediment revealed many leucocytes, erythrocytes and tubercle bacilli.

A cystoscopy performed on July 22, 1931, showed an edematous, congested and partly ulcerated bladder. The right ureteral orifice was edematous but allowed a number 4 ureteral catheter to pass into the ureter for a distance of 15 cm. The left ureteral orifice showed a typical golf-hole deformity with upward retraction. A number 4 ureteral catheter could not be passed into this ureter. The urine from the right kidney was pale and hazy in appearance, albumin graded + + + was present, with 30 leucocytes and 180 erythrocytes in each cu. m.m. of this urine. The Ziehl–Neelsen stain upon the sediment demonstrated tubercle bacilli. The intravenous phenolsulphonphthalein test resulted in a total elimination of 14 per cent on the right side and only a trace of the dye was present in the bladder urine in 15 minutes.

The plain urinary tract x-ray showed a normal sized right kidney and a large left kidney. A cystogram obtained by the injection of 80 c.c. of 5 per cent sodium iodide solution demonstrated regurgitation to the right ureter and pelvis. After the injection of 45 c.c. of 20 per cent iopax solution intravenously no shadow was seen in the left pelvis or ureter in any of the series of films taken 15 minutes, 45

Case #3, Fig. 2A. This cystogram was made with the injection of 80 C. C. of 5 per cent sodium iodide solution. It shows a normal bladder outline, regurgitation into the right ureter and pelvis which are dilated.

Case #3, Fig 2 B. Intravenous urography shows absence of function in the left kidney and dilatation of right kidney pelvis and ureter.

minutes, 1 hour and 15 minutes, 2 hours and 6 hours after the injection. A dilated pelvis and a dilated and tortuous ureter was evident on the right side. A diagnosis of left autonephrectomy and advanced tuberculosis of the right kidney was made. Palliative treatment as indicated was recommended.

SUMMARY AND CONCLUSIONS

Three among 65 tuberculous children were discovered to have renal tuberculosis. In one the disease was bilateral and in two it was unilateral. In one of the latter, nephrectomy was performed with a successful immediate outcome.

Children with persistent pyuria, albuminuria and ardor upon urination should be promptly given the benefit of the newer facilities for complete urological examination.

The reluctance of the pediatrician and the general practitioner to take advantage of urological consultation and cystoscopy must be overcome. Urologists should, on every possible occasion, point out to them the relative simplicity and harmlessness of the newer instruments and methods.

NOTE. The illustrations were prepared by Mr. Leo Massopust, Marquette University School of Medicine.

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Calcium Deficiencies In Pregnancies and Its Influences Upon the Child*

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Superior

The subject of the proper calcium maintenance of the body has been gaining much prominence in medicine during the past few years. This is because we have learned the normal calcium requirements and reactions. A great deal of this research has been in pregnancies and children, and justly so because of the importance that this inorganic salt has on the health of the mother and later the future of her offspring. Unfortunately its physiology has seemed so complex and the methods of detection so technical that many cases go unnoticed and untreated. It is true that manifest tetany in the pregnant is a rare condition and when it does exist the mortality is extremely high; yet latent tetany is comparatively common and when left untreated predisposes the child to early spasmophilia and rachitis.

The theories advanced as the causative factors have changed considerably. At first it was thought that the toxic substances formed from disturbed nitrogen metabolism was the causative agent. This gave way to the parathyroid theory where there exists a hypofunction of the parathyroid gland. The one accepted today by the greatest number is the calcium privation theory where there exists a drain of calcium upon the system such as we have in pregnancies.

The principal etiological factors involved are:

1. *Diet:*

The diet necessary for the average American is one gram of calcium daily and yet it has been found that our average daily con-

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sumption is only forty-five hundredths gram or less than half the required amount (1).

It is during the latter part of pregnancy that an additional drain is placed on the mother. The fetus increases its calcium content from 5.39 grams at the twenty-eighth week to 30.51 grams at the fortieth week (2).

An over abundance of fat in the diet stops the absorption of what calcium is to be had —this being passed off as calcium phosphates and insoluable calcium soaps.

2. *Season:*

Apparently with the termination of pregnancy toward the earlier months of spring, having to go through the short winter days without much sunshine and being kept indoors by the cold, adds materially to the privation of calcium.

3. *Hypofunction of the Parathyroid Gland:*

This may be an insufficiency in the activity of a normal gland or to an injury during a previous thyroidectomy. At least this gland seems to be the governing agent which enables the system to pull from the bone trabeculae the reserved calcium when needed (3).

4. *Absence of Vitamin D:*

When absent there is an increased excretion of calcium in the intestine with a diminished deposition of calcium (4).

SYMPTOMS

The symptoms may be divided into first:

Objective: A syndrome described by E. C. Hartley (5).

a. Insomnia.
b. Irritability of disposition unusual to the patient.
c. Cramp-like or aching pains in the legs and thighs.
d. Edema of the extremities apparently not associated with cardiac or nephritic pathology.
e. Paresthesia of the extremities affecting large areas or in some cases only the fingers or toes.

Subjective:

a. A blood calcium having a low normal or below normal.
b. Increased bleeding time and coagulability.
c. Muscle excitability as evidenced by the galvanic current.

With the above symptoms being quite varied and before progressing further, a short review of the functions of calcium will enable one to see why the symptoms may be so diversified in their appearances.

Calcium, sodium and potassium in definitely balanced proportions are necessary for normal cardiac action, for the proper nerve impulses to be passed from nerve to muscle, maintenance of the membrane permeability in balance, for the coagulation of the blood, for the bone building process of our bodies, and lastly, calcium along with magnesium holds to a great degree the more irritating salts sodium and potassium in balance (7).

DIAGNOSIS

1. The diagnosis is made by the history. The pains in the legs must be differentiated of course from pains from varicosities, faulty posture, wrong type of shoes, etc. Edema from other causes by urine examination, blood pressure and cardiac examination. The insomnia can be verified readily by the members of the family, also the change in disposition. Dermatographia is a frequent finding.

2. The coagulability of the blood.

Blood taken from the lobe of the ear. When the coagulability is over eight minutes, it is quite suggestive of a low blood calcium. I use the capillary method and the watch glass method.

3. The galvanic current.

Erb's phenomenon (6). With a drop of the cathodal opening contraction below five milliamperes calcium deficiency must be suspected.

4. Blood calcium.

Gaven & Cantarow's method of determining the blood calcium. They gave as normals from nine to eleven milligrams per one hundred c.c. Eight milligrams or lower shows a lowered blood calcium.

TREATMENT

a. Dietary.

The diet of Crawford and Williamson has proved most satisfactory and is as follows: (8)

Eat one citrus fruit daily.
At least one leafy vegetable.
At least the yolk of one egg.
Drink three glasses of milk daily.

In addition to this they may have whatever other diet they may choose for themselves, so as to keep their weight within normal limits. The average gain in weight for nine months should be twenty to twenty-five pounds.

b. Hygienic.

Routine care of the body with emphasis upon outdoor activities for at least two hours daily.

c. Therapeutic.

1. Calcium salts.
2. Viosterol or cod liver oil.
3. Ultraviolet light.

In the use of calcium salts this is quite dependent upon the individual. To raise the blood calcium to normal or above is the desired result. Irrespective of the calcium compound used there are certain rules to be followed. Calcium should be given during the time when the acid reaction of the intestine is greatest, from one and a half to three hours after meals. Calcium absorption takes place when the fat content of the diet is comparatively low. Investigation has shown that any calcium salt in aqueous solution will raise the serum calcium if not influenced by food or other known inhibitory factors (9).

In my work I use first:

1. Calcium lactate drams, one and one-half four times daily.
2. Calcium chloride drams, one three times daily.
3. Calcium gluconate intramuscularly.
4. Parathyroid extract.

When the calcium is started I give viosterol, twelve drops three times daily. If there is not a marked improvement in the clinical symptoms within one week the calcium is stopped by mouth and calcium gluconate, ten c.c. of ten per cent, is given intramuscularly along with twenty units of the parathyroid extract every other day. This is continued until the clinical symptoms have improved and the blood calcium is ten milligrams per one hundred c.c. or more and the electrical reaction is above normal. At this time the calcium is discontinued, cod liver oil is substituted for the viosterol, and continued throughout the rest of the pregnancy unless the same symptoms reoccur. If they do calcium and viosterol are again given. Ultraviolet ray is resorted to only during the winter months and in those cases where there is no improvement with calcium and viosterol.

The effect of latent tetany upon the child is best shown by two cases I have had an opportunity to follow during the past two years. It was evident that these patients had a latent tetany by first, the clinical symptoms, and by the low blood calcium and an increased muscular excitability to the electrical galvanic current. The clinical symptoms were controlled by other drugs than calcium. No special instructions were given as to diet, exposure to sunshine, and no cod liver oil was given. I was anxious to note the influence upon the child.

CASE REPORTS

CASE I. Para one: Seen first at four months. Had been feeling so well that she thought it unnecessary to consult a doctor before.

At this time blood calcium was eleven milligrams per one hundred c.c. At six and one-half months, she had pains in the thighs which she stated seemed deep in the muscles also in the arms, with tingling sensations in the hands and feet. Had an insomnia quite marked; that is, she had a hard time getting to sleep, was easily awakened and after sleeping even for only a half hour when awakened was unable to sleep any more. Blood calcium at this time was eight milligrams. Muscle excitability to the electrical current at this time was normal. Pyramidon was given for pains and luminal for the insomnia. At eight and one-half months she still had the deep seated pains in thighs, and had some edema of hands and feet. The urine was free from albumin. The blood pressure never showed any increase in the systolic pressure, and cardiac action was normal. Blood calcium at this time was seven milligrams. Electrical reaction showed four milliamperes cathodal open contraction. Patient was delivered of a full time baby. The labor was fourteen hours and spontaneous delivery—baby boy seven pounds eleven ounces. Blood calcium of infant on seventh day was seven milligrams; coagulability eight minutes. Child showed a marked hypertonia of muscles of arms and legs, positive Chvostek's, cried much, very restless and would awaken with a start upon the slightest noise. Was a hard child to feed with a great tendency toward vomiting. On the fifteenth day the muscle reac-

tion was four milliamperes cathodal open contraction.

At this time viosterol and calcium were started both on the mother and the child. Mother was given drams one and one-half of calcium lactate four times daily and baby fifteen grains three times daily —twelve drops of viosterol to mother three times daily and the baby received three drops three times daily. In ten days the child was sleeping its quota per twenty-four hours, was taking its food easily and was making a satisfactory gain in weight. The blood calcium was eleven milligrams, coagulability was four and one-half minutes. The muscle excitability was seven milliamperes. This child has never shown any signs of tetany since.

CASE II. Para two: First child full time. Seen first time at third month. Stated that she had suffered from a marked hyperemesis for six weeks. Blood calcium ten and twenty-five hundredths milligrams per one hundred c.c. Electrical excitability above eight milliamperes cathodal open contraction. At fifth month marked pains deep in thighs and in calf of legs. Very irritable, with marked insomnia. Blood calcium was eight milligrams. Muscle excitability cathodal open contraction above five milliamperes.

Pyramidon and luminal were used as necessary to control symptoms. Blood calcium one week prior to delivery was seven and five-tenths milligrams per one hundred c.c. Muscle excitability four milliamperes. Spontaneous delivery after six hours labor. Birth weight of female child seven pounds and four ounces. Inanition fever third day temperature one hundred four. Fluids crowded—Ringer's solution. Child showed a marked spasticity of legs and arms—positive Chvostek's—showed a marked reaction to noises and bright light. Cried a lot and vomited its food in projectile manner. Blood calcium on seventh day six milligrams. Coagulability was eight and one-half minutes. Muscle excitability galvanic current four milliamperes, cathodal opening contraction.

Calcium lactate and viosterol to mother and child were started in the same manner and dosage as in case one. Marked improvement in the child was noted in three days, muscle excitability six milliamperes cathodal open contraction, coagulability of blood four and one-half minutes. Blood calcium eleven milligrams. To date the child has not shown any tendency toward tetany.

In both cases calcium was continued for three weeks along with viosterol. At this time, cod liver oil was given to the baby instead of viosterol and all treatment to mother stopped.

I have seen one death from maternal tetany. Three weeks following the death of mother, the child was brought to me because of its crying, restlessness, vomiting, lack of gain in weight.

I found a marked spasticity of the muscles of the arms and legs, a positive Chvostek and a muscle reaction to the galvanic current of three milliamperes.

The child was placed on a lactic acid formula. Calcium chloride was given, ten grains four times daily. Elixir luminal one-fourth dram was given morning and night for two days, then discontinued. Cod liver oil was started and continued throughout the first year; sun baths were given. All symptoms were gone in three weeks and although I have seen this child off and on for four years no more tetany like symptoms appeared although a mild rachitic condition developed after the ninth month.

SUMMARY

That maternal tetany exists quite commonly is shown by the fact that Frankl–Hockwart (10) were able to collect fifty-three cases; distributed as follows, twenty-eight occurred late in pregnancy, nineteen shortly after delivery and twenty-nine during lactation.

That tetany in the newborn exists in the manifest form has been reported by Kehrer (11), who reported six cases and by Shannon (12) who reported three cases.

The importance of tetany is best shown, I believe, by quoting from that wonderful treatise on tetany written by Alfred F. Hess (13) and this being put in italics—

"The incidence of tetany, including its latent form, is comparable to that of infantile rickets and greater than that of any other constitutional disorder at this period of life."

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Acute Substernal Pain*

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Owing to the increase in the incidence of heart disease the public is becoming somewhat heart-minded and as a result we are being confronted more and more with conditions requiring decisions, often hurridly, as to whether or not we are dealing with a serious disorder. Acute substernal pain may be due to several conditions some of which may result in death within a few minutes or hours after the onset, while often pains of this character are only those of a neurosis. Our problem is not only to differentiate these conditions rapidly but to treat them promptly and thoroughly in an effort to meet this ever increasing problem.

Angina pectoris is a common cause of this type of pain and as a rule attacks people with: more or less enlargement of the heart; a narrowing of the coronary arteries; a pericarditis; aortic regurgitation; syphilitic aortitis; or in some cases no macroscopic lesions. It is more common in men than in women and usually occurs after fifty. Severe mental and emotional strain, toxins such as tobacco, influenza, pneumonia, acute rheumatism and diabetes are common predisposing causes. More cases are seen among private patients than in the dispensaries.

The pain comes on frequently after some severe muscular effort such as climbing or walking against a strong wind; when exposed to cold air; during a gastric disturbance, or some excitement. It may occur spontaneously without any apparent exciting cause.

The pathological condition present is very uncertain although most authorities feel it is a circulatory disturbance. The theories of temporary or transient ischaemia of the heart muscle, and the overstretching of the ventricles, and the distension of the coronary arteries are not definitely established as being true.

Pain in angina pectoris comes on suddenly and is intense or agonizing, lasting a few minutes usually during which time the patient remains very still even holding his breath for fear of increasing the pain by movement of the chest. The pain is often referred to the left arm down to the elbow and sometimes to the fingers. The facial expression is one of agony due to the severity of the pain and also to the fear of death so commonly present. The skin is cold and clammy and has an ashen grey color. The pulse usually is regular and not increased in frequency. The heart is often enlarged to the left. The blood pressure and electrocardiogram show no characteristic changes.

Occasionally a prodromal stage in this condition occurs and consists of the symptoms of incipient heart failure. These are mild substernal pain or distress, especially on exercise, and radiating into the left arm accompanied by palpitation and sudden general weakness and faintness. This type responds very well to treatment.

Angina pectoris occurring in an individual already suffering with some cardiac disturbance such as enlargement, irregularity, insufficient valves, or with hypertension increases the seriousness of the case and makes the prognosis more unfavorable. However, many serious cases occur when there are no abnormal findings.

The course of this serious condition may be classified under the heading of five groups, the first of which includes those cases of rapid death in which one or two attacks occur sometimes ending in a condition known as status anginosis. The second consists of those with a duration of one and one-half to two years during which there is a varying number attacks. The chronic form is the third type lasting upwards of ten years with a varying number of attacks and increasing intensity. The fourth group consists of a small number of cases which may last for months or years with great severity and yet completely recover. The fifth group consists of those cases presenting the prodromal symptoms referred to previously, which, if treated properly, may never develop true angina.

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CASE REPORTS

CASE 1. In August, 1930, we saw a laboring man 45 years of age who was complaining of pain, sudden in onset and of very short duration, when he walked from his home to his work. This was especially noticeable when a strong wind was blowing. He also noticed this a few times in the evening after eating a large meal.

Careful physical examination including x-ray and electrocardiogram failed to show any definite findings except a slight dyspnea on exertion.

In an effort to get this man to rest in bed we lost him as a patient, and did not see him again until February, 1931. At that time he was very edematous and had all the symptoms of a myocardial failure. He is still disabled.

Would rest in bed with adequate supportive treatment back in August, 1930, have prevented this failure?

CASE 2. Recently a man 56 years of age came to our office complaining of attacks of pain beneath the sternum, associated with pressure in the chest on exertion and especially after eating even a small meal. This condition had existed for about two months and seemed to be getting worse. He noticed that when inactive these attacks did not occur.

Examination showed slight cyanosis of the lips, a slightly enlarged heart with no murmurs, a blood pressure of 120–90, a negative Wassermann, blood chemistry and urine. X-ray examination of the gastro-intestinal tract was negative. Under rest in bed for two weeks this pain and dyspnea disappeared. This seems to be a case of the prodromal type of angina and we have hopes of preventing any immediate failure or accident.

CORONARY OCCLUSION

Coronary occlusion which is the most common cause of sudden death is characterized by pain beneath the sternum lasting from two to eight hours and requiring large doses of morphine for relief. It often radiates to the arm or neck and is accompanied by a weak thready pulse, a definitely low blood pressure and dyspnea either constant or paroxysmal. The respirations are usually rapid and shallow. In twenty-four hours a mild fever varying from 100° to 102°, a leukocytosis of 9,000 to 25,000 and a pericardial friction rub are common. In some cases vomiting of blood occurs shortly after the onset of the condition. There are many atypical cases of coronary occlusion very difficult to diagnose. The pain may be epigastric, simulating gastric or cholecystic diseases. The pericardial friction rub may be present only for a few minutes and be hard to detect accordingly.

The electrocardiograph is a valuable adjunct in the diagnosis when it is possible to obtain a tracing soon after the accident. In 70% of the cases according to Willius a negative T wave in isolated or combined leads occurs. This however alone is not entirely characteristic of coronary occlusion.

The pathology in these cases is essentially that of intimal atherosclerosis. The left coronary artery is the most common site of the lesion.

This condition occurs more commonly in men than women, especially in those who have been subjected to severe mental strain. The tension of modern business and living seems to be the underlying cause for the increase of this serious condition. Infections, tobacco, alcohol, and syphilis probably play minor but definite roles.

The prognosis is very grave and depends on the integrity of the heart muscle; the condition of the general vascular system and the cooperation of the patient. Death may occur suddenly in the first attack without any antecedent symptoms, or from progressive myocardial failure after several minutes or hours of painful seizures. Rupture of the heart occurring several hours or days after the accident is not uncommon. The painful seizure may cease spontaneously and death occur years later from some disease outside the cardiovascular system.

A bank cashier age 40 came to our office on December 15th, 1930, complaining of mild attacks of pain beneath the sternum when walking in the cold air. These attacks were more of an oppression than pain and were of such short duration that they seemed to him to be of no concern. On December 18th, several hours after eating a heavy meal he was seized with a severe attack of pain, weakness, and mild dyspnea. The pain was localized to the region beneath the sternum radiating upward to the neck but not down the arm. It was associated with recurring attacks of extreme weakness and anxious expression, cold, clammy skin and a very weak but regular pulse. The blood pressure which on December 15th, had been 120–80 was now 98–70. The pain lasted over a period of six hours during which time repeated doses of morphine were administered. Three hours after the initial symptoms the patient vomited profusely, part of which was predigested blood. Two hours later this was

repeated. In twenty-four hours the temperature was 101° and the leukocyte count was 18,000. The pulse remained weak, the heart tones distant, and the patient very exhausted. During the course of the next six days the temperature and leukocyte count gradually dropped to normal. The blood pressure varied from 98 to 102 systolic and the general condition of the patient improved.

In February an electrocardiographic tracing showed an inverted T wave in lead three. All other examination was essentially negative except for a mild hyperacidity of the gastric juice. In June, 1931, this man's electrocardiographic tracing was normal, his blood pressure was 118–80, the heart tones were normal in intensity and his general condition was excellent.

He has returned to work part time and is apparently none the worse for his accident. This case is unquestionably a case of coronary thrombosis.

NEUROTIC TYPE

Another very common type of pain beneath the sternum is the neurotic type. This is so often seen in women at the menopause, in individuals who have had relatives or friends recently die of heart disease, or in the neurasthenic individual whose pain is an avenue of escape from some unpleasant task.

This pain is usually present following some mental disturbance, worry, sorrow, or fatigue and does not usually radiate to the arm or neck. The cardiac signs are normal including the cardiogram.

The diagnosis of this can only be made by a very careful history, physical examination and a keen analysis of the patient. Probably this plus the history are the most important factors arriving at a diagnosis of this sort. We must be ever cautious of this type because they too may develop the organic troubles even after several months or years of functional symptoms.

This was brought rather forcibly and unhappily to our attention by the development of a coronary thrombosis in a woman 44 years of age whom we had been treating over a period of several months and whom we had perhaps too emphatically assured that her condition was harmless. Probably nowhere in the practice of medicine is it necessary to use more judgment than in this type of trouble.

Recently we saw a young man, age 40, who was complaining of a pain beneath his sternum which came on at irregular intervals and which was causing him no little concern. His father-in-law had died of heart disease during the past six months, and his predecessor in business had succumbed to a coronary accident a year previous.

Careful examination including electrocardiograph tracings failed to show any pathological conditions and a diagnosis of neurosis was made. Under bromides his pain has entirely disappeared.

TREATMENT

The treatment of acute substernal pain, once the diagnosis is made, often requires prompt action.

During an attack of angina pectoris the nitrites and morphine to the point of control are indicated. Rest in bed on a light diet and one of the various types of drugs which increase the coronary flow such as theobromine and its allies or euphylline are indicated between attacks. All foci of infection should be eliminated, the use of tobacco and alcohol discontinued and all exciting factors kept away. In arteriosclerosis, even in the absence of syphilis, two to five grains of the iodides three times daily over a long period seems to be beneficial.

In coronary occlusion, morphine to the point of control is definitely indicated. The nitrites have little if any effect. Stimulants such as caffein are often of value. Digitalis is contra-indicated except for subsequent heart failure. The coronary dilating drugs are very essential.

Rest in bed over a period of two to three months followed by a similar partly active term is necessary for healing of the pathological condition. Resumption of the previous occupation provided it is not associated with intense nervous strain may be attempted at this time, but the lives of these patients thereafter should be as free from excitement and tension as possible.

In the neurotic type of pain, careful assurance of the type of trouble present and the use of bromides will often obtain prompt relief. Here again let me caution you about the need of occasional checking of these people—not often enough to make them uneasy, but often enough to catch the early signs, if there be any, of organic troubles.

There are a great many other types of pain beneath the sternum which I have not mentioned, but my effort today is in behalf of those cases presenting themselves to us more and more each year with the sudden onset of substernal pain. Is it or is it not serious and what does their future hold for them?

The Injection Treatment of Internal Hemorrhoids*

By GEORGE G. STEBBINS, M. D.
Madison

The recent revival of interest of the injection method of treating internal hemorrhoids has brought with it an increasing number of articles and small books upon the subject. This form of procedure is similar to, and has developed nearly coincidently with the injection of varicose veins of the lower extremities. For generations there have been non-cutting treatments for hemorrhoids and the principal reason is that people have a fear and perhaps a legitimate fear for pile operations.

Up to and including our present time there are not many practitioners who care to do, or are trained to do, a thorough rectal and sigmoidoscopic examination. Too often the examination to determine *why* the hemorrhoids are present is ignored. The operation may be performed hastily at the conclusion of the morning's operative schedule and local post-operative care left to an assistant if any is even given. Large tubes and gauze packs are crowded into a gaping and roughly divulsed sphincter, with the thought of allowing escape of gas, and the controlling of hemorrhage. The pain experienced with the removal of the plug, the generous dose of castor oil, and weeks of discomfort are vividly recalled by patients, and are often related to friends. Due to this implanted fear patients seek a cure without the knife.

The injection of hemorrhoids is thought to have been done first by Mitchell of Clinton, Illinois, in 1871. He kept the method secret and sold the secret to many non-medical followers, and itinerant "pile-curers". As a result of this inauspicious start, the method quickly fell into disrepute.

In 1900 Goodsall and Miles (1) of England disposed of the subject in their book with three lines, saying that the method would not cure and probably would result in abscess or fistula. Lynch (2) of New York in 1914 considered the method a good one for use in a few selected cases. P. Lockhart Mummery (3) in 1923 described the method in some detail, recommending it in many cases, when properly performed. T. Chittenden Hill (4) of Boston injects many cases, but still prefers the ligation operation unless contraindicated or refused. Goldbacher (5) of Philadelphia and Terrell (6) of Richmond, Virginia, state that they treat nearly every case of internal hemorrhoids successfully by injections. Yeomans (7) at the Polyclinic Hospital in New York City believes that about 50% of the cases are suitable. Buie, (8) of the Mayo Clinic, approves of this method when the cases are properly selected and treated by careful observance of correct technique. It may be seen then that men with a wide experience in rectal work are of late recognizing this method of treatment.

SELECTION OF CASES

From a study of the recent literature, it seems that one's personal views and experience play considerable part in selecting suitable cases for injections. In general, the uncomplicated internal hemorrhoid of moderate degree best lends itself to this type of treatment. The more advanced cases depend upon individual factors for the patient and doctor to consider. External hemorrhoids of any variety, thrombotic or external skin tabs, should not be injected, for any solution strong enough to sclerose varicosities will produce a slough when injected beneath the skin. When the internal hemorrhoids are complicated by chronic anal fissure, fistula, polyps, large external skin tabs, etc., it is best to remove them at the same time with the complicating lesions. The inflamed, strangulated, or markedly ulcerated cases should be operated upon and not injected. A spasmodic contracted sphincter usually indicates the presence of infection. There again injection may or may not be advisable. Hemorrhoids which on the least exertion protrude constantly through an atonic sphincter are generally best dealt with by operation.

CHEMICAL AGENTS

Carbolic acid in a variety of combinations has been one of the most popular agents. The well known Shuford's solution contains

* Presented before the Dane County Medical Society.

twenty-five per cent carbolic acid. Yeomans (7) uses a modified Shuford's, reducing the carbolic one-half, i.e., to twelve and one-half per cent strength. In England phenol, five to twenty per cent, has been used almost entirely. Goldbacher (5) uses a five per cent phenolized oil, preferably a cotton seed oil, or Wesson oil. In 1913 Terrell (6) first used quinine and urea hydrochloride five per cent in aqueous solution. In 1923 he reported its use in three thousand cases with uniformly good results. It has been used with satisfaction by many others since that time, being particularly recommended by Buie (11) of the Mayo Clinic and Hayden (9) of Boston. The tendency among most workers is to use the weaker solutions to avoid sloughing, and accomplish their work by milder chemical reactions. In my own experience the five per cent quinine and urea hydrochloride in aqueous solution has been very satisfactory.

TECHNIQUE OF INJECTION

No preliminary preparation is necessary, except that the lower rectum should be clear of feces. The patient is placed in the left Sims' position, with the buttocks slightly over the table edge. The necessary equipment to make an injection is simple. A long narrow 1 cc. ground glass syringe, with the smallest hypodermic needle is as satisfactory as are the more complicated syringes. Where more than 1 cc. is required, I use a 4 cc. syringe and an 18 gauge needle about 10 cm. long to avoid interference with vision while injecting. Illumination is obtained from a head-lamp similar to that used by surgeons for tonsillectomies. There are several types of satisfactory anoscopes in use, the Otis, Kelly, Brinkerhoff, and Hirschman. The one I prefer for the majority of cases is patterned after the Hirschman anoscope.

A careful survey of the number and location of the hemorrhoids requiring treatment is made. If a hemorrhoid is actually bleeding at the time of the examination, it should be injected first. Otherwise choose one of the smaller piles to start with. Then introduce only one-half cc. into it. All writers upon this subject warn about the possibility of quinine idiosyncrasy, and I feel that this should be kept in mind. Although alarming symptoms have arisen from the oral administration of quinine, no one has reported such a reaction following the injection of quinine and urea hydrochloride. The site of the injection into the hemorrhoid being chosen, the spot is touched with tincture of iodine or five per cent mercurochrome on an applicator. The amount of solution required in any particular hemorrhoid, after the preliminary testing injection, is variable. It is necessary to infiltrate the tissues about the varicosities, until a rounded swelling is produced, but not enough to cause a tightness of the overlying mucosa. If too much is injected a slough will follow and if too little a complete fibrosis will not occur. The needle should be introduced to a point about midway in the tumor, and during the injection may be moved around among the varicosities. I always draw back on the plunger of the syringe before injection to determine if I am in a vessel, but to date have never seen any blood in the syringe barrel. The injection is done slowly, and the needle allowed to remain in place for one minute after the injection solution is introduced. No pain should follow the introduction of the needle, and if present, usually means that the introduction is too close to the ano-rectal line. A properly executed injection gives the patient no subsequent pain or discomfort. Their only report at the next visit is a slight sensation of fullness in the rectum for three to five hours after the injection, but this did not in the least interfere with their occupational duties.

ACTION OF SOLUTIONS ON HEMORRHOIDS

Buie, (12) of Rochester, studied microscopically the pathological changes provoked by quinine and urea hydrochloride injections. He states that, "within thirty minutes after injection of the solution into the tissues, leukocytic infiltration can be observed. At the end of two hours lymphocytes begin to appear in the submucous stroma around the venous spaces and varicose veins. After eight to ten hours the general appearance is that of a subacute inflammatory process with

(Continued on page 872)

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EDITORIALS

THREE YEARS AGO

JUST three years ago our cooperation was asked in making one of the many studies of the Committee on the Costs of Medical Care. After listening to a respresentative of the Committee explain that the data sheet in question contained two hundred and thirty-nine questions which were to be answered once a month for eleven months, we sat down at our typewriter and wrote an editorial. We did not publish that editorial for fear that the future developments might indicate that we were jumping to conclusions.

Now that the final majority report, and all the interim studies are in our possession, we want to quote one paragraph from that editorial written three years ago.

"So much has been said about the high cost of medical care that we welcome an investigation and wish it well. We recognize, we believe, some of the difficulties that any such survey faces. We have promised the present effort our cooperation and we would have it attain success. But the basic questionnaire that we have seen has such glaring defects that we can but wonder at their occurrence. We cannot but admire the fine ingenuity of the framers of the examination but we fear that they have left the highway of breadth of vision to become hopelessly lost in a labyrinth of detail. Nor can we refrain from suggesting that the data thus gathered, so divorced from all other economic considerations, can prove conclusively so many things that may not be so."

Now read the editorial from the Journal of the American Medical Association which we are privileged to print following.

THE COMMITTEE ON THE COSTS OF MEDICAL CARE*

THIS week the Committee on the Costs of Medical Care completed its five-year study and made available a final report. An abstract and analysis of the report appears under Medical Economics in this issue of THE JOURNAL. The recommendations of the majority of the committee will not come as a surprise to the thousands of physicians who have followed closely the trend of the studies as indicated by the reports published from time to time since 1927. The director of the work, Harry H. Moore, PH. D., published a book called "American Medicine and the People's Health," which revealed his personal bias for insurance schemes and, indeed, for governmental practice. So definite was the trend of the committee's studies in this direction that one must view the expen-

* J. A. M. A., Dec. 2, 1932.

We Wish You A Happy Holiday Season

diture of almost a million dollars by the committee and its final report with mingled amusement and regret. A colored boy spent a dollar taking twenty rides on the merry-go-round. When he got off, his old mammy said: "Boy, you spent yo' money but where you been?"

Knowing the composition of the Committee on the Costs of Medical Care, physicians will not be surprised that a significant minority should have dissented from the majority report. True, the majority included seventeen men with the degree M. D., of whom seven are listed as in private practice and the others as public health officials or representatives of institutions or special interests. The minority report, however, is supported by Dr. Olin West, the secretary of the American Medical Association; George E. Follansbee, the chairman of the Judicial Council; M. L. Harris, a former President and for many years a member of the Judicial Council, and also Drs. A. C. Christie, Kirby S. Howlett, A. C. Morgan, Robert Wilson and N. B. Van Etten. Moreover, two representatives of American dentistry, Drs. Herbert E. Phillips and C. E. Rudolph, dissent in a separate minority report.

Briefly, the majority report recommends that medical practice be rendered largely by organized groups associated with hospitals, and it expresses the hope that these groups will maintain the personal relationship between patient and physician so essential to good medical care. The rendering of all medical care by groups or guilds or medical soviets has been one of the pet schemes of E. A. Filene, who probably was chiefly responsible for establishing the Committee on the Costs of Medical Care and in developing funds for its promotion. Such practice has, moreover, on various occasions had the endorsement of representatives of some of the eight foundations that contributed financial support. In contrast with this recommendation of the majority report, the minority bluntly recommends that "united attempts be made to restore the general practitioner to the central place in medical practice." This it does with good reason, for experience has shown that more than 80 per cent of all the ailments for which people seek medical aid can be treated most cheaply and most satisfactorily by a family physician with what he can carry in a handbag. All of the expensive studies and investigations carried out by the Committee on the Costs of Medical Care have not disproved this fact. In elaborating its recommendations, the majority report also endorsed industrial practice involving those schemes in which corporations care for employees and their families, as well as expansion of student health services at universities, so that these may serve faculty and townspeople as well as students. Most of the university services studied by the committee are in large cities where such an expansion is manifestly impossible. The Journal has pointed out repeatedly that such practices will mean the destruction of private practice; that they represent exploitation of physicians for the gain of business; that they put medical schools into unfair competition with their own graduates, and that they are, in a word, "unethical." Knowing the composition of the Committee on the Costs of Medical Care, it is interesting to find the pet plans of many of its members so sweetly elaborated in the majority report.

Both the majority report and the chief minority report are concerned with public health services. The majority report recommends extension of all basic public health services to make them available to more and more people. The minority report views with alarm further invasion of governmental agencies into the practice of medicine. And what a curse such invasion has been! Who today fails to realize the menace inherent in the expansion of the Veterans' Bureau? Even most radical health officials, moreover, are finding that their best policy will be to give medical practice back to the medical profession.

The minority report does recommend that the care of the indigent by the government be expanded with the ultimate object of relieving the medical profession of this burden. Already some county medical societies have worked out cooperative plans with their communities which seem to work practically in this direction. To what extent such plans may lead toward state medicine is, of course, problematic. Certainly physicians who are paid for the care of the indigent will be able to lessen fees for those able to pay only part of a usual medical fee.

The real question for consideration is the problem of providing funds for the care of the 10 to 20 per cent of serious medical and surgical conditions for which wage earners usually find themselves poorly, if at all, prepared. The majority report would place medical costs on a group payment basis through insurance, taxation or both but without abolishing practice on an individual fee basis for those who prefer it. Profiting by the experience of foreign countries, it is recommended that health insurance be distinctly separated from unemployment

insurance or insurance against loss of wages. On the contrary, the minority report says flatly:

> "It seems clear that recommendations for further trial and expansion of voluntary insurance schemes in the United States are entirely inconsistent with the Committee's own findings. To recommend that our own country again experiment with discredited methods of voluntary insurance is simply to ignore all that has been learned by costly experience in many other countries as well as our own.
>
> "Voluntary insurance schemes are now in operation in many parts of the United States and are increasing in number and in size. In many places these schemes are being operated in accordance with the plan recommended by the majority of the Committee, that is, by making contracts with organized groups of the medical profession. That they are giving rise to all the evils inherent in contract practice is well known. Wherever they are established there is solicitation of patients, destructive competition among professional groups, inferior medical service, loss of personal relationship of patient and physician, and demoralization of the profession. It is clear that all such schemes are contrary to sound public policy and that the shortest road to the commercialization of the practice of medicine is through the supposedly rosy path of insurance."

This need not be taken to mean that the minority report is opposed to any individual carrying insurance against the occurrence of a major illness or operation so that he might receive at such time funds sufficient to pay the hospital and the physician he might select. No doubt, insurance companies could sell such policies most reasonably if a sufficient number of persons could be induced to insure themselves and their families in this manner. Such a procedure is foresighted, American, economical. It preserves personal relationship and the free choice of physician and hospital; moreover, it makes the patient responsible to the physician and places squarely on the physician the responsibility for the care of the patient.

Both the majority and minority reports recommend continued study of medical economic problems by every type of agency. Certainly the studies already published by the committee indicate the value of such studies and the necessity for having facts on which to base conclusions and recommendations. This would seem to be particularly true in relationship to such studies as are available of various industrial medical services and of corporate practice. The minority report is particularly resentful that the majority made recommendations on the basis of inadequate studies in this field. Thus it says:

> "It is the belief of the minority group that the majority report has presented this question in a distorted manner. The evils of contract practice are widespread and pernicious. The studies published by the Committee show only the favorable aspects. They were selected because they were considered the most favorable examples of this type of practice in the United States. For each of these plans a score of the opposite kind can be found. The evils are inherent in the system although they may be minimized when a high grade personnel is found either among employees or medical group, or both."

Specifically, the recommendation of the minority group reads:

> "The minority recommends that the corporate practice of medicine, financed through intermediary agencies, be vigorously and persistently opposed as being economically wasteful, inimical to a continued and sustained quality of medical care, or unfair exploitation of the medical profession."

These two reports represent, therefore, the difference between incitement to revolution and a desire for gradual evolution based on analysis and study. The majority report urges reorganization of medical practice, the development of centers, insurance; if necessary taxation to provide funds; expansion of public health services. The minority is willing to test any plan that may be offered if it conforms to the medical conception of what is known to be good medical practice. Indeed, the minority recommends, "that methods be given careful trial which can rightly be fitted into our present institutions and agencies without interfering with the fundamentals of medical practice." One seems to hear that famous medical aphorism that has come down through the centuries: "Prove all things; hold fast to that which is good."

In addition to the majority report and the first minority report, several others by smaller groups appear in the final report. The dental members, as previously mentioned, oppose the plan for centers as utopian. They favor some form of compulsory health insurance under professional control. Dr. Edgar Sydenstricker would not sign because he felt that the recommendations did not deal with the fundamental economic problem the Committee was formed to consider. If by this he meant that the problems of the wage earner and of the poor include the provision of food, fuel, housing, clothing and transportation as well as medical service, he will find most of the world in agreement with him.

Early in the majority report it is emphasized that low incomes are largely responsible for the problems which the committee was created to investigate, but that subject is apparently never mentioned again in the majority report.

In September the Board of Trustees and the Judicial Council of the American Medical Association met with a group of physicians representing various portions of the country, to hear an analysis of eco-

nomic problems. Last week the Board of Trustees met with the secretaries of state medical societies and with the editors of the state medical journals. At this meeting Dr. William Allen Pusey, speaking for a committee appointed at the previous session, presented an analysis of the principles on which medicine must stand, its responsibilities to the public, and the return it has a right to expect from that public. In the twelve points under which he assembled his conclusions, several are especially significant in relation to the final report of the Committee on the Costs of Medical Care. They are briefly:

> "The good of society must be the sole aim of its public policies and the good of the patient the first consideration in the relations between physicians and patients.
>
> "Experience has shown that the vast majority of disease conditions afflicting man can be most satisfactorily and economically diagnosed and treated by a competent individual general practitioner.
>
> "Medicine's chief concern must be for the individual physician; the service rendered by individual physicians in the aggregate constitutes the great bulk of medical service. The quality of service which is given depends on the competency of the individual physicians who give it.
>
> "The medical profession asks a career of independence under conditions of free and dignified competition.
>
> "In its ideals of independence, medicine has a right to control its own affairs. Its history of capacity to do so and altruism justifies this claim."

The Journal, under the auspices of the Board of Trustees, representative of organized medicine in this country, urges physicians to familiarize themselves with the abstract of the final report of the Committee on the Costs of Medical Care which appears in this issue, if not with the complete report. It urges, after careful consideration, support of the minority report signed by the representatives of the American Medical Association in the committee. The alinement is clear—on the one side the forces representing the great foundations, public health officialdom, social theory—even socialism and communism—inciting to revolution; on the other side, the organized medical profession of this country urging an orderly evolution guided by controlled experimentation which will observe the principles that have been found through the centuries to be necessary to the sound practice of medicine. On the one side are alined the forces that would practice one kind of medicine for the rich, another for the wage earner and the indigent; on the other side are the physicians who know that, from the point of view of the physician who studies bodies and minds, all are human beings. The physicians of this country must not be misled by utopian fantasies of a form of medical practice which would equalize all physicians by placing them in groups under one administration. The public will find to its cost, as it has elsewhere, that such schemes do not answer that hidden desire in each human breast for human kindliness, human forbearance and human understanding. It is better for the American people that most of their illnesses be treated by their own doctors rather than by industries, corporations or clinics. The American Medical Association, through its Board of Trustees, supports the minority report. No doubt the House of Delegates, at its session in Milwaukee next June, will urge every physician affiliated with the Association to do likewise.

ENDOCRINE PRODUCTS

THE practicing physician is bewildered at times by the rapid developments in the field of endocrine therapy. This phase of medical treatment has received an unparalleled amount of attention during recent years, and research promises substantial achievement in simplifying, as well as relieving, some of the intricate disturbances of endocrine function.

The average practitioner finds it difficult properly to assess the proclaimed virtues of many of these new preparations. Consequently, a considerable responsibility should be assumed by those in a position to evaluate the asserted properties of new endocrine products. The results of such studies and observation should be promptly communicated to the profession at large for their proper guidance.

A great deal of credit must be extended to the manufacturers of most of these products for their effort and expense in obtaining a judicious appraisal of new preparations. However, such study can be made best as a group project rather than by individual practitioners. The great majority of physicians would prefer to have a clinical test made by a few recognized authorities in the therapeutic field concerned, upon a large number of properly controlled cases, before any preparation is disseminated widely in the retail field. Furthermore, such a critical study would be of decided service to the patient, since most of these products are very expensive, and their use for experimental purposes in private practice sometimes causes a distinct financial hardship. J. H.

THE PRESIDENT'S PAGE

Reginald H. Jackson

PASSING THE RUBICON

When he arrived at the banks of the Rubicon which divides Cis Alpine Gaul from the rest of Italy—he stopped to deliberate—. At last he cried out: "The die is cast" and immediately passed the river. PLUTARCH—Life of Julius Caesar.

PROBLEMS steadily increasing in number and ever more complex confront the officers of state and national medical societies. Some are of such a nature that they may advisedly wait for time to aid in their solution. Certain others are so inherently vital to the best interests of the public and the medical profession that procrastination or dilatory tactics in the making of a decision may well result in an accumulation of allied problems embracing great potential injury to the best interests of the public and the medical profession. Upon our decision and action of today may depend not only our own fate but that of those who follow us.

That our profession is entering a critical stage in this state must be apparent to all of you. Lest you think me unduly alarmed, let me present a recent problem brought to my attention only some two weeks ago when, through a request of your secretary, a conference was obtained with representatives of the Employers Mutual Insurance Company of Wausau in an effort to ascertain facts in regard to the rumored establishment and operation by them of a special clinical diagnosis group for the examination and periodic reëxamination of potentially some 7,000 employes in Milwaukee, engaged in the so-called dusty trades. At the conference the representatives of the Insurance Company intimated that

1. They were ready to start functioning November 1.
2. They had x-ray and other clinical laboratory equipment in the process of installation.
3. They had engaged the services of a full time physician.
4. That they had gone thus far without notifying us as they had decided their project would be opposed by organized medicine and therefore had not sought consultation with its representatives.
5. They felt secure in that they were incorporating a Special Industrial Research Laboratory under whose charter they would operate.
6. They did not intend to "practice medicine", their object being a purely humanitarian one, as many men were dying and being disabled in increasing numbers from silicosis, and that the medical profession was doing nothing about it.
7. Medical men were not as a rule equipped or competent to make the desired physical examinations.
8. That where they were capable, equipped and available their fees were prohibitive.
9. Their investigations revealed that properly supervised and directed mass examination might reduce the cost per examination including a flat x-ray plate of the chest to below $2.00 per individual examination.
10. The steadily increasing compensation claims for death and disability arising from these trades were such as to cause them great concern, etc., etc.
11. Certain physicians including some already in the employ of the Insurance Company would act in an advisory capacity, with representatives of organized medicine.
12. *Whether the employe found on examination to be afflicted would be informed of his exact condition and legal rights under the compensation occupational disease provision had not as yet been determined, etc., etc.*

If the facts are as represented, there can be no question of the advisability of and necessity for the requisite examinations, primarily from

the standpoint of the employe, and only secondarily from the viewpoint of the employer.

Neither at this conference nor at a later one held in Milwaukee at which were present the President and certain other officers of the Insurance Company, representatives of the employers, and the Council of the State Medical Society, was it possible to convince those promoting the project that it would be inimical to the best interests of the public and especially labor to carry out the plan as outlined to us. Nor were we able to persuade them that among the 850 practitioners of medicine in Milwaukee County there were many who were both willing and capable, and equipped with proper facilities to render the desired service in a satisfactory manner.

When informed that all the facilities of medicine were at their command if they would but use them, the reply was, they would not.

Aside from the question of how such a present plan affects the public interest and especially the interest of labor, we are here concerned with a direct professional problem as to the legal right of this proposed corporation of laymen to practice medicine. Even though in this instance such practice consist solely in the making of a diagnosis, our tacit consent at this time to the slightest deviation from the basic fundamental principles underlying what statutory provisions govern the practice of medicine in this state may well be the entering wedge which will permit the entrance of other factors inimical to the public interest and destructive of the ideals of organized medicine.

Granted the contention of the Insurance Company that their primary object is a purely humanitarian one, the ever recurring reference on their part to the cheapness of the proposed mass examinations recalls to mind that type of humanitarianism characterized by Chief Justice Dixon of the Wisconsin Supreme Court in the following words:

"It is possible to hold the disc of the dollar so close to our eyes that it excludes from sight every object of public interest and blinds us to every sentiment of humanity."

Lest this quotation be misunderstood, I use it solely forcibly to bring to mind exactly how the public interest may be jeopardized by the proposed corporate form of practicing medicine.

If the making of a diagnosis by special examinations constitutes the practice of medicine (as it does by both express statute and express decision of the Wisconsin Supreme Court) as much as and aside from the prescribing of treatment and the proposed corporation obtains its charter and is permitted to carry out its plans, what is to prevent some other organization of laymen from incorporating and carrying out a method of treatment? If this should come to pass in this state as it has in others through the unwatchful, lackadaisical disinterestedness of organized medicine the public would be left to the mercy of quacks, charlatans, and those whose greed would be masked under the guise of medicine.

My last message was headed "Close Ranks". Again I repeat it. As one in whom you have seen fit to vest great responsibilities, whose duty it is to see these problems as they pass in endless succession over the desk of your secretary, I assure you that in this particular problem we are again at a forking in the road. We must cross the Rubicon. We must make a decision. We must ACT—NOW—not twenty years hence. Inasmuch as certain high minded employers interested in this particular occupational disease hazard could not be made through conference to sense the fundamental ethical difference between a clinical service carried on by a given factory for the good of its employes, often at a great sacrifice, and the incorporation of a third party in this instance the child of the Insurance Company to sell for a profit (concealed in lower premiums) hired medical services to employers of factory labor, said employers being virtually owners of the Insurance Company, we are reluctantly forced to the conclusion that if we are not to be unfaithful to the public interest we must face this issue and fight it to a finish. With your support, that is just what your officers intend to do.

SOCIETY PROCEEDINGS

ASHLAND-BAYFIED-IRON

At a meeting of the Ashland-Bayfield-Iron County Medical Society held on Wednesday evening, November 9th, the following officers were elected to direct the Society for the coming year: President, Dr. J. W. Prentice, Ashland; Vice-President, Dr. John K. Shumate, Pureair Sanatorium, Bayfield; Secretary and Treasurer, Dr. R. O. Grigsby, Ashland; Censor, Dr. C. J. Smiles, Ashland. J.W.P.

BARRON-WASHBURN-SAWYER-BURNETT

The Barron-Washburn-Sawyer-Burnett County Medical Society met at the Commercial Hotel at Barron the latter part of October for a banquet and meeting.

Judge H. S. Comstock, county judge of Barron County, spoke on child welfare. This was followed by an address on "Occupational Dermatosis," illustrated with lantern slides, by Dr. S. L. Henke of Eau Claire. Dr. C. A. Harper, state health officer, discussed the work of the State Board of Health and was assisted by Dr. F. P. Daly, deputy state health officer.

BROWN-KEWAUNEE

A meeting of the Brown-Kewaunee County Medical Society was held November 15th at Hickory Grove Sanatorium. Dinner was served at six o'clock.

The principal speaker of the evening was Dr. John W. Towey of Powers, Michigan, superintendent of Pine Crest Sanatorium. His subject was "Collapse Therapy."

Dr. James Colignon of Green Bay also spoke on the same subject and demonstrated some cases and x-rays.

The talks given by both the speakers were very interesting and this proved to be an unusually successful meeting. W.E.M.

CALUMET

The annual meeting and dinner of the Calumet County Medical Society was held at the Great Northern Hotel, Chilton, October 26th.

The following officers were elected for the ensuing year: President, Dr. J. J. Minahan, Chilton; Vice-President, Dr. I. N. McComb, Brillion; Secretary-Treasurer, Dr. J. W. Goggins, Chilton; Delegates Drs. J. W. Goggins and F. P. Knauf, Kiel.

The speakers of the evening were Dr. N. J. Knauf of Chilton and County Judge George M. Goggins.

Dr. Knauf discussed the diagnosis and treatment of fracture of the pelvis and lower extremities. He stressed particularly the advantages to patient and physician in treating these fractures where possible by the use of the Traction Counter Traction appliance.

Judge Goggins related his experiences with county indigent appeals for sick relief and hospitalization. J.W.G.

CHIPPEWA

A meeting of the Chippewa County Medical Society was held at the Hotel Northern, Chippewa Falls, on Tuesday, November 15th, with a dinner at six-thirty o'clock.

Dr. J. A. Kelly of Chippewa Falls was elected president and Dr. Merton Field, also of Chippewa Falls, was chosen secretary for the year 1933.

Following election of officers, Dr. John W. Harris, Madison, spoke on "The Toxemias of Pregnancy."

CLARK

On November 16th the Clark County Medical Society held a meeting at Owen, Wisconsin. A vote was taken by the members present regarding the panel system under the State Compensation Act. Unanimous vote was cast for course one.

Dr. R. P. Potter of Marshfield gave a talk on "Diagnosis of Bone Disease." He illustrated his talk with lantern slides.

Dr. S. E. Williams of Chippewa Falls spoke on "Newer Things in the Practice of Medicine and Surgery" as presented at the Tri-State meeting at Indianapolis, Ind.

A committee was appointed to draw up a set of resolutions regarding the indigent poor in Clark County and present said resolutions to the County Board. This committee consisted of Dr. Benjamin Dike of Owen; Dr. H. H. Christofferson, Colby, and Dr. R. H. Wink of Granton. A.L.S.

EAU CLAIRE AND ASSOCIATED

A dinner meeting of the Eau Claire and Associated Counties Medical Society was held at the Hotel Eau Claire at six-thirty o'clock Monday, October 31st.

The following program was given:

"A Simple Treatment for Trichomonas Vaginalis Vaginitis" by Dr. Woodruff Smith of Ladysmith.

"Fractures of the Hip" by Dr. Myron O. Henry, Minneapolis.

FOND DU LAC

Dr. D. V. Meiklejohn of Fond du Lac was elected President of the Fond du Lac County Medical Society at its annual meeting held on November 9th at the Hotel Retlaw. Dr. J. C. Yockey, Fond du Lac, was chosen vice-president and Dr. Joseph C. Devine, Fond du Lac, was elected secretary and treasurer to succeed Dr. H. R. Sharpe of Fond du Lac who held that office for the past six years.

Speakers at this meeting were Drs. Arnold S. Jackson and George H. Ewell, both of Madison.

GRANT

The thirtieth annual meeting of the Grant County Medical Society was held in the Grantland Club Rooms at Lancaster on Tuesday afternoon, November 15th.

The program consisted of the following:

"Coronary Thrombosis" by Dr. Laurence Cooley of Dubuque, Iowa.

"The Acute Abdomen" by Dr. Arnold S. Jackson, Madison.

"Some Urologic Problems Met in General Practice" by Dr. W. E. Bannen of La Crosse. This paper was illustrated with lantern slides.

"Medical Economics in Wisconsin. A report of the State Study" by J. G. Crownhart, Secretary of the State Society.

"Mortality in Acute Appendicitis" by Dr. Erwin R. Schmidt of the department of surgery, University of Wisconsin. This paper was also illustrated with lantern slides.

All officers were re-elected for the year 1933. A six o'clock dinner concluded the meeting. Upwards of forty physicians were present at this meeting including guests from neighboring county societies.

GREEN

The Green County Medical Society held its fall meeting on the evening of November 15th at the Eugene Hotel, Monroe.

The vote for referendum on panel practice was as follows: Sixteen members voted in the affirmative to support legislation to provide a free choice of physicians for the injured workmen which would mean the abolishing of panels. None voted in the negative.

The program, which consisted of a symposium on lesions of the large bowel, had the following speakers:

Dr. Harold Marsh, Madison, gave the diagnosis; Dr. J. N. Sisk, Madison, the x-ray findings, and Dr. R. H. Jackson, President of the State Society, gave a lecture on the treatment.

Preceding the program, a banquet was served to twenty-five physicians. After the banquet the meeting was called to order. Dr. R. H. Jackson was called upon to give us a report of the investigation committee. He gave us a splendid report of what his committee had been doing up to the present time. J.F.M.

MANITOWOC

The Manitowoc County Medical Society held a most successful meeting at the K. C. Community Hall, Manitowoc, Thursday evening, October 27th.

Dr. C. A. Harper, state health officer, gave a short talk on "The Care of the Indigent Sick in Iowa"; Dr. H. M. Guilford, director of the bureau of communicable diseases, State Board of Health, spoke on "Communicable Diseases With Special Reference to Tularemia and Psittacosis."

Dr. Nathan Schneck, Manitowoc, read a paper on "The Status of Acuity of Hearing and Vision in the Public School".

A committee composed of officers of this Society will select forms to be used in chest clinics which have been taken over by the County Society. The meeting closed with a buffet luncheon. E.C.C.

MARINETTE–FLORENCE

The monthly meeting of the Marinette–Florence County Medical Society was held on October 13th at the Hotel Marinette. A good attendance was present, including guests from Escanaba, Michigan. Dr. G. R. Duer, delegate, reported proceedings of the state meeting at Milwaukee. Dr. Damon A. Brown of Madison presented a paper with slide illustrations on "A Study of Chronic Infection in the Male Genital Tract." C.H.B.

MILWAUKEE

There were 225 physicians present at the November meeting of The Medical Society of Milwaukee County, which was held at the Hotel Pfister on November 11th.

Upon opening the meeting, President Currer requested all present to rise and stand at attention for a moment as a tribute to those physicians of Milwaukee who served in the World War, many of whom were present.

The following program was presented:

"Diagnosis of Pelvic Viscera With the Aid of Brominol." J. J. Eisenberg, M. D.

"Sterility—Investigation and Treatment," Benjamin E. Urdan, M. D.

"Angina Pectoris," Robert Bruce Preble, M. D., professor of medicine, Northwestern University Medical School.

PIERCE–ST. CROIX

The Pierce–St. Croix County Medical Society met in River Falls, Thursday, November third. A six-thirty o'clock dinner at the Hotel Gladstone preceded the meeting. There were ten members present.

Concerning the referendum on panel practice, the vote was eight for course one, i.e., contacting the insurance companies to secure their voluntary cooperation, and two for course two, or in support of legislation.

The following were elected to serve as officers for 1933: President, Dr. Julius Blom of Woodville; Vice-President, Dr. Chalmer Davee of River Falls; Secretary-Treasurer, Dr. A. E. McMahon of Glenwood City; Censor for three years, Dr. G. M. Dill of Prescott; delegate, Dr. A. E. McMahon of Glenwood City; alternate, Dr. O. H. Epley of New Richmond.

Following the business meeting, Dr. W. H. Hengeseter of St. Paul discussed "Functional Neuroses" in a very able and instructive manner. A.E.McM.

POLK

The Polk County Medical Society at its regular meeting on October 21st passed the following motion

in regard to the free choice of physicians under the compensation laws:

"It is moved and seconded that the Polk County Medical Society of the state of Wisconsin go on record as favoring the free choice of physicians by the injured when being cared for under the Workmen's Compensation Act. That the secretary be instructed to write the Secretary of the State Medical Society advising him of the action of the Polk County Medical Society and urge him, together with the officers of the State Society, to secure this free choice, first through conference with the insurance companies, and should that measure fail to attempt to secure legislation toward that end." G.B.L.

PRICE–TAYLOR

At a meeting of the Price–Taylor County Medical Society held at Phillips on November 18th, the following were elected officers for 1933.

President, Dr. E. A. Riley of Park Falls; Vice-President, Dr. Lester Nystrum of Medford; Secretary, Dr. Edgar B. Elvis; Censor for three years, Dr. G. E. MacKinnon, Prentice; Delegate Dr. E. A. Riley and Alternate Delegate, Dr. Edgar B. Elvis. E.B.E.

RACINE

The regular meeting of the Racine County Medical Society was held November 17th, at the Elks Club at eight o'clock.

Dr. F. A. Stratton, professor of surgery, Marquette University School of Medicine, addressed the physicians on the subject of "Acute Lesions of the Upper Abdomen."

Dr. H. M. Richter, clinical professor of surgery at Northwestern University School of Medicine, spoke on "Thyrotoxicosis." A general discussion followed.

After the scientific program, a short business meeting was held and refreshments were served. S.J.

ROCK

Members of the Rock County Medical Society met at Pinehurst Sanatorium on the afternoon and evening of October 25th. Talks were given by Miss Iva L. Hartman, superintendent of the Sanatorium; Mr. Bernard M. Palmer, trustee, and Judge Jesse Earle.

Dr. William S. Middleton, associate professor of medicine, University of Wisconsin, lectured on "Changing Problems in Tuberculosis" while Dr. T. J. Snodgrass, Janesville, talked on "Our Experience with Phrenectomy."

Following the meeting, dinner was served to the physicians and the board of trustees.

TREMPEALEAU–JACKSON–BUFFALO

Members of the Trempealeau–Jackson–Buffalo County Medical Society met at the Galesville Clinic, Galesville, on November 11th.

Election of officers took place at this meeting for the year 1933. They are: President, Dr. R. R. Richards of Blair; Vice-President, Dr. C. T. Clauson, Galesville; Dr. R. L. MacCornack, Whitehall, Secretary-Treasurer.

Dr. F. C. Dixon of the Mayo Clinic, Rochester, was the principal speaker of the meeting.

WINNEBAGO

The first fall meeting of the Winnebago County Medical Society was held on October 21st in the staff room of Mercy Hospital. County Judge D. E. McDonald spoke on the subject of "Medical Care and Hospitalization of the County Indigent Poor." Dr. Neil Andrews of Oshkosh spoke of incidents relative to his experiences as a patient in the Massachusetts General Hospital.

The Society held another monthly meeting in the staff room of Mercy Hospital, Oshkosh, Friday evening, November 18th.

The Society unanimously decided in favor of course number one, relative to the panel system in the state of Wisconsin.

Dr. F. Gregory Connell, Oshkosh, presented a paper entitled "Post Operative Ulcers of the Stomach." Dr. Connell will also deliver this paper at the Western Surgical convention to be held in Madison in December. M.C.H.

FIRST COUNCILOR

The annual meeting of the First Councilor District of the State Medical Society was held at the Oconomowoc Health Resort, Oconomowoc, at two o'clock on Wednesday, October 26th. The following program was presented:

"The Psycho-Neurotic Manifestations Following Head Injuries" by Dr. John L. Garvey, Milwaukee. Discussion of this paper was opened by Dr. J. C. Hassall of Oconomowoc.

"Indication for Surgery in Brain Injuries" by Dr. Percival Bailey of Chicago. Dr. Stanley J. Seeger, Milwaukee, opened this discussion.

Following the scientific program, Dr. A. W. Rogers and Dr. Wilkinson of Oconomowoc showed moving pictures of a recent trip for salmon fishing in New Brunswick. Dr. Rogers was host to the members at a dinner served immediately following the meeting. There were upwards of sixty members present for one of the largest district meetings in recent years.

MILWAUKEE ACADEMY OF MEDICINE

A meeting of the Milwaukee Academy of Medicine was held on November 15th. Dr. Norman F. Miller, professor of gynecology and obstetrics, University of Michigan, was the speaker of the evening. His subject was "Disturbances of Menstruation."

MILWAUKEE OTO–OPHTHALMIC

The monthly meeting of the Milwaukee Oto–Ophthalmic Society was held on Tuesday, November 22nd, at the Wisconsin Club at six-thirty o'clock. The following scientific program was presented:

"Treatment and Cure of Nasal Polyps. A Report of Thirty Cases" by Dr. R. H. Rice, Milwaukee.

"Otitic Generalized Infections, Origin and Management" by Dr. A. Kovacs, Waukesha.

THE WOMAN'S AUXILIARY

Mrs. Fred A. Nause, Jr., Sheboygan, *President*
Mrs. Eben J. Carey, Milwaukee, *President-elect*
Mrs. Walter Ford, Sheboygan, *Secretary*
Miss Ruth Buellesbach, Madison, *Executive Secretary*
Mrs. R. G. Arveson, Frederic, *Treasurer*
Mrs. James C. Sargent, Milwaukee, *Press and Publicity Chairman*
Mrs. James F. Percy, Los Angeles, Calif., *National President*
Mrs. Rock Sleyster, Wauwatosa, *National Convention Chairman*

National Convention, Milwaukee, June 1933

The Woman's Auxiliary In the Role of Esther*

By MRS. WALTER JACKSON FREEMAN
President Woman's Auxiliary to the American Medical Association

It is indeed an honor to be invited to speak to you this evening, and your secretary's liberal offer of 10 minutes completely turns my head.

The greeting I am accustomed to receiving from the President of a Medical Society is a warm handshake for the benefit of the gallery, and for my own guidance an empathic aside—"Not over three minutes, please."

If the physician's duties were confined to the highly technical fields of healing the sick, teaching, and research work, the Woman's Auxiliary would never have been born. The rise of *preventive* medicine, however, opened a vast and unexplored territory, where lay helpers might be profitably enlisted as "hewers of wood and drawers of water," reserving for the medical profession the responsibility of planning and directing the projected undertakings.

In most instances the nearest lay helper available accepts her Auxiliary duties with her wedding ring, and nothing is easier or more natural—one might say more inevitable—than the step from the telephone and the plate warmer to the County Medical Society Building, there to concert with other wives further means of advancing their husbands' work.

Before taking any action, however, the wise ones among them will turn to their Bibles and study the tactics of that consummate strategist, Queen Esther. Let me urge you all to read anew that story of Ahasuerus and his two queens, Vashti the brave and Esther the canny. It opens, you will remember, with a perfectly priceless description of a great feast and of the utter consternation of the King and the seven princes when Vashti refused to appear before them. Feminism upon them for fair! Would "all the ladies of Media and Persia" unite in defying their lords?

The first step was to send a letter to "all the hundred and twenty and seven provinces," advising their governors that Vashti had been put away for insubordination, and by unanimous vote "every man should bear rule in his own house."

As you think back to the day when the Auxiliary first appeared on the medical horizon, does any of this sound like home?

Esther's whole story is apropos but I shan't attempt to finish it. I should only spoil its naive and dramatic perfection. I have referred to it because of one special point which emphasizes the position of the Auxiliary better than any other incident that I know.

As Esther stood in the inner court of Shushan the palace, fresh from the bath, young, beautiful, perfumed, magnificently apparelled, her tongue clave to the roof of her mouth, her knees shook, and her heart quaked within her. She was on forbidden ground. If the King extended the golden sceptre, she was saved, and might hope for success in her great effort to rescue her people. Should he frown, her life was forfeit. In her own words, "If I perish, I perish."

* Read before the House of Delegates of the State Medical Society of Wisconsin, Milwaukee, Wisconsin, September 13, 1932. Mrs. Freeman died on October 28, 1932.

Just so does the Auxiliary stand today, before organized medicine, awaiting you gentlemen's recognition. More fortunate than Esther, who had nothing on which to rely save prayer and the beauty parlor, the Auxiliary is the sole possessor of additional qualifications of great value in promoting the health of the community. Nothing of real importance can be undertaken, however, until that golden sceptre is extended. Yours is the decision as to what is to be done, who is to do it, and how, and when, and where.

Most of our Auxiliary women are also members of other organizations—women's clubs, Y. W.'s, Parent-Teachers Associations, church groups, American Legion Auxiliaries, League of Women Voters, etc., etc.—a membership which gives us the entrée into the inner circles of feminism. Many of you feel that the hospitalization of veterans is a burning issue. Has it occurred to you that if you make up your minds on a concerted educational campaign, you can enlist all the Auxiliary members to spread your propaganda? Those among us who are also members of the American Legion Auxiliary can probably arrange meetings where your representatives may present the views of the Medical Society. Do you wish to plan a series of educational health conferences throughout your state? Take a leaf from Georgia's book. There the State Medical Society and the State Health Department arranged a program of 20 such public meetings covering the entire state, and placed all the details of advance publicity and local arrangements into the Auxiliary's hands. The results are so outstanding that in the future the Auxiliary chairman is to report annually to the House of Delegates with all the other standing committees.

Do you wish a campaign for periodic health examination? Ask the Delaware Auxiliary. They know how, and the Anti-Tuberculosis Society paid all the bills. Would you teach the young about tuberculosis? Your neighbor, the Minnesota Auxiliary has had high school prize essay contests for two years, with radio broadcasts of the ten leading essays. Are your health laws insufficiently known and obeyed? Send an S. O. S. to the Kentucky Auxiliary. Their study course on state health laws was distributed to every club woman in Kentucky, and was published as the September, 1931, issue of the Bulletin of the State Health Department. If your library is in chaos, call on the Shreveport, Louisiana, Auxiliary. Those ladies not only paid for the binding of the Medical's Society's journals, but classified and indexed the books and, if memory serves me right, have taken over the full charge of the library.

Do old age and poverty haunt your dreams? The New Hampshire, New Jersey, and Colorado Auxiliaries are evolving plans for the relief of distressed physicians. The Pennsylvania Auxiliary makes the Benevolence Fund of the State Medical Society its chief objective, and every one of the 45 Auxiliaries contributes regularly to this splendid and much needed cause. In the past 5 years the Auxiliary has raised $10,600 for this fund, which under the able management of Dr. Walter F. Donaldson now amounts to $110,000.

You all know that once the women decide they have to have a thing, they can find 1001 ways of getting it. Why not turn this aptitude to account? Put them to work on those parts of your health program that may safely be left to untrained volunteers. They will appreciate the compliment of being called upon, they will give you valuable openings among lay organizations otherwise closed to you, and from their reactions to your new propositions you may better gauge those of the general public.

Two other thoughts and I am done. A large and active Auxiliary materially increases attendance at the state and county medical meetings. The women in official position feel it a duty to attend, the socially minded enjoy meeting their friends, all agree that a little trip will do Husband good—and eager or indifferent, Husband goes. In Pennsylvania attendance at our State Medical Society meetings has increased 20%, an increase laid by the Society entirely at the door of the Auxiliary.

And now I close with "the last, the best of all the game." Work in the Auxiliary

strengthens enormously the ties between husband and wife, gives them a common interest, an understanding of each other's problems, a respect for each other's viewpoint. This spirit of friendly companionship spreads in an ever-widening circle from household to household, rounding off corners, discovering new excellences, until its influence is felt in the whole medical fraternity.

Oh, King Ahasuerus, when will you extend the golden sceptre?

KENOSHA COUNTY AUXILIARY ORGANIZED

A woman's auxiliary to the Kenosha County Medical Society was formed on Tuesday evening, November fifteenth, when the ladies met at a joint meeting with the members of the County Medical Society.

The following officers were elected for the coming year: Mrs. Alexander Schlapik, president; Mrs. J. H. Cleary, vice-president; Mrs. A. M. Rauch, secretary-treasurer; Mrs. C. H. Gephart, publicity chairman, and Dr. Helen Binnie, medical adviser.

Luncheon was served following the business meeting.

MILWAUKEE COUNTY

The November meeting of the Milwaukee County Auxiliary was attended by approximately eighty-five members. Colonel Fred Best, State Chairman of the National Economy League, addressed the group on the subject "The Veteran in Peace Times". The Auxiliary is particularly directing its activities toward circulating information concerning the physicians' service bureau and the speakers' bureau in lay organizations, and in raising sufficient money to place Hygeia in rural schools which do not now subscribe to the magazine.

Four new members came into the Auxiliary in November.

Tribute to Mrs. Walter Jackson Freeman, President of The Woman's Auxiliary to the American Medical Association, read by Mrs. Rock Sleyster at the regular meeting of the Woman's Auxiliary to The Medical Society of Milwaukee County, November 11th, 1932.

"On October 27th, the officers of this organization received the sad news of the death of Mrs. Walter Jackson Freeman, President of the Woman's Auxiliary to the American Medical Association.

"Mrs. Freeman became ill following her attendance at the meeting of the Pennsylvania State Auxiliary, and failed to rally following an operation. She has visited our society so recently that our members are familiar with her history and it would be useless to repeat her training, her antecedents, her accomplishments or her efforts in behalf of our national organization.

"During her short stay as our guest, she won the hearts of all she met. Her plans so carefully worked out were most helpful to us in shaping our efforts for the coming year. Her enthusiasm and her ideals were an inspiration to us and stimulated a determination on our part to extend every effort to make the coming national meeting in Milwaukee the outstanding event which she wished it to be.

"We shall miss, more than we can express, her wise leadership and guidance but we pledge to her memory an Auxiliary united in its devotion to carry on to the best of our ability the work which she outlined for us to do."

ROCK COUNTY

Thirty members attended the dinner meeting of the Rock County Auxiliary in October. They are planning a Thanksgiving party, with the Medical Society members as guests, to be given at the Spanish Tavern in Beloit on November twenty-ninth.

Their particular project is the development of a speakers' bureau to supply speakers to various lay organizations in the community.

SHEBOYGAN COUNTY

The Sheboygan County Auxiliary held a luncheon meeting at the Association of Commerce on the second of November. The president, Mrs. Theodore Gunther, announced that a series of monthly luncheons had been planned.

WINNEBAGO COUNTY

The Woman's Auxiliary to the Winnebago County Medical Society held its regular luncheon meeting in Oshkosh on November first with twenty-five members present. Mrs. C. J. Combs presented an interesting account of the beginning of the medical society in Winnebago county, telling of its growth and accomplishments. There was a social hour before the meeting was adjourned.

On November twenty-eighth the ladies met at the Sign of the Fox in Neenah.

TO COUNTY PUBLICITY CHAIRMEN

The state press and publicity chairman appreciates the cooperation which she is receiving from some of the county press and publicity chairmen, and hopes that each county will realize the necessity of sending a monthly report of their activities so that the auxiliary page may be made both interesting and helpful to the membership of the state auxiliary. Reports should be sent by the fifteenth of each month to Mrs. James Clyde Sargent, 2924 N. Stowell Avenue, Milwaukee.

STATE CHAIRMEN

September 1932–1933

Program Chairman: Mrs. Raymond C. Meyer, Plymouth.

Public Relations Chairman: Mrs. Henry G. Gramling, 2203 S. Layton Blvd., Milwaukee.

Hygeia Chairman: Mrs. James V. May, 1421 Grant Street, Marinette.

Press and Publicity Chairman: Mrs. James C. Sargent, 2924 N. Stowell Avenue, Milwaukee.

Organization Chairman: Mrs. Eben J. Carey, 2028 N. 51st Street, Milwaukee.

Assistant Organization Chairman: Mrs. Thomas O. Nuzum, 932 Mineral Point Avenue, Janesville.

Archives and Historian: Mrs. Frederick A. Leighton, Sheboygan Falls.

Parliamentarian: Mrs. Reuben H. Bitter, 85 Oakland Avenue, Oshkosh.

NEWS ITEMS AND PERSONALS

Dr. W. Homer Krehl, formerly of Wisconsin Dells, has opened offices at 102 King Street, Madison.

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Dr. C. W. Henney, Portage, was elected congressman to represent the second district of Wisconsin.

—△—

Dr. H. A. Vennema of Menominee, Michigan, died on October 20th of coronary thrombosis. He was president of the Menominee County Medical Society, Michigan, and frequently attended the meetings of the Marinette–Florence County Medical Society.

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A thief, believed by police to have been a "dope" addict, broke into the offices of Drs. Henry A. Ott and George N. Pratt of Neenah and escaped with a quantity of morphine, an overcoat, a vest and sweater from Dr. Ott's office. Nothing of value was taken from Dr. Pratt's office.

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Dr. M. A. Cunningham of Janesville was elected president of the Ancient Order of Hibernians at a meeting in November.

—△—

Mr. Horace Kent Tenney, 72, Chicago attorney and father of Dr. Horace K. Tenney, Jr., Madison, died at his home in Winnetka, Illinois, on October 29th. Mr. Tenney was a former professor of law at the University of Chicago.

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Three Wisconsin physicians were re-elected to the board of trustees of the International Medical Assembly at its annual meeting in Indianapolis in October. They are: Dr. G. V. I. Brown, Milwaukee; Dr. Arthur G. Sullivan, Madison, and Dr. John M. Dodd, Ashland.

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Members from out of the city who visited the offices of the State Medical Society in Madison in November included the following: Dr. W. Homer Krehl, Wisconsin Dells; Dr. Oscar Lotz, and Dr. John Huston of Milwaukee; Dr. F. E. Butler, Menomonie; Dr. Gilbert E. Seaman, Milwaukee; Dr. H. H. Fredrick of Westfield and Dr. Wilson Cunningham of Platteville.

Dr. Helen Binnie, formerly of 615—56th Street, Kenosha, has opened an office in her residence at 7609—25th Ave., Kenosha.

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Drs. A. J. McCarey and I. E. Levitas of Green Bay attended the annual clinical congress of the American College of Surgeons held in St. Louis in October.

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Dr. Philip Marquart, Milton Junction, a graduate of Harvard University Medical School in June, 1931, has accepted a position as resident physician in the Northern State Hospital at Sedro Woolley, Wash. He finished internship at Ford Hospital, Detroit, and had been visiting at the home of his parents at Milton Junction since September first.

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Dr. C. J. Radl, who was recently granted a license to practice in Wisconsin, has opened an office at Pardeeville.

—△—

Dr. Burton Clark, Jr., Oshkosh, who spent the past year and a half in postgraduate study in surgery at Lakeside Hospital, Cleveland, returned to Oshkosh and resumed his practice the first part of September.

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Dr. J. P. Skibba, Kaukauna, in November moved his offices from the Foster building to the Farmers and Merchants bank building.

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Mrs. J. A. Diamond, wife of Dr. J. A. Diamond of Frederic, died on November 14th following a severe illness after acquiring an infection of the right leg.

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Dr. Robert W. Burns has opened an office for the practice of medicine in the Minahan building, Green Bay. Following his graduation from Marquette University School of Medicine, Dr. Burns spent a year as resident physician at Johnston Emergency hospital in Milwaukee, going from there to New York where he was resident physician at the New York Lying–In hospital.

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Dr. P. R. Fox, Madison, who underwent an operation in October, has been removed to his home, 28 West Wilson Street.

Dr. T. J. Snodgrass, Janesville, will direct a community chorus which will sing "The Messiah" at Christmas time in Monroe.

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Dr. George H. Williamson of Neenah was elected as director of the Wisconsin Anti-Tuberculosis Association for a term of three years at its annual meeting held in Milwaukee on November 4th.

Dr. H. M. Coon of Stevens Point was elected a member of the executive committee of the W. A. T. A., at this meeting.

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Dr. Ralph M. Carter, Green Bay, addressed the staff meeting of the Holy Family Hospital at Manitowoc on November 4th on the subject of "The Treatment of Fractures."

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Dr. A. E. Dillman of Steuben is assisting Dr. A. J. McDowell of Soldiers Grove in his practice.

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Dr. William F. Lorenz, Madison, acted as general Chairman of the Madison American Legion post football banquet honoring the University of Wisconsin eleven at the Loraine Hotel, Madison, on November 29th.

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Dr. Joseph F. Smith, Wausau, spoke on "Industrial Injuries" before members of the Rhinelander Safety Conference on November 16th.

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Dr. Maysil Williams, director of child hygiene for the North Dakota Department of Health, spent several days in Madison studying the child welfare work of the State Board of Health. While in Madison, Dr. Williams was the guest of Dr. Charlotte J. Calvert, director of the bureau of child welfare of the State Board of Health.

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Dr. Francis J. Pomainville of Wisconsin Rapids, who underwent an operation on October 31st, has completely recovered and resumed his practice.

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Dr. Joseph H. Hardgrove of Eden was elected Assemblyman from Fond du Lac County.

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MILWAUKEE

Dr. J. Gurney Taylor was elected president of the Wisconsin Anti-Tuberculosis Association at the annual meeting of the Association on November the fourth.

Other Milwaukee physicians elected to office in the Association were:

Dr. C. H. Stoddard, recording secretary; Dr. Gilbert E. Seaman, member of the Executive Committee.

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Dr. Henry J. Gramling, director, and a past president of The Medical Society of Milwaukee County, and chairman of the Health Department Advisory Committee, was appointed to the State Board of Medical Examiners on November 2nd. The appointment was made by Governor Philip LaFollette for a period of three years, as of July 1, 1932.

Dr. Gramling succeeds Dr. J. Gurney Taylor, whose term expired on July 1, 1932.

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Oral examinations by the Milwaukee County Civil Service Commission to select forty interns for the Milwaukee County General Hospital, Wauwatosa, will be held on December 2nd and 3rd at the hospital. These internships will become effective on July 1st when the present staff of interns completes a year's work at the hospital.

Applicants are limited to graduates of Class A medical schools.

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Dr. and Mrs. S. I. Biller spent several days in Indianapolis, Indiana, the latter part of October. Dr. Biller attended the sessions of the Inter-State Postgraduate Medical Association of North America.

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Dr. Leon J. Liest, who has been a practicing physician in Milwaukee for a number of years, left the latter part of September to take up his residence in Cutbank, Montana, where he will continue his practice of medicine.

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Dr. Chester C. Schneider presided at the farewell luncheon given recently for Mr. C. C. Lane, executive secretary of the Y. M. C. A., who left Milwaukee November 1st for Rock Island, Illinois, to become general secretary of the Y. M. C. A.

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At the convention of the International Society of Health Officers, held in Washington, D. C., the latter part of October, Dr. John P. Koehler, Commissioner of Health, Milwaukee, was elected vice president of the Society, and editor of its official publication.

Dr. Roy W. Benton, Health Commissioner of Shorewood, also attended this convention.

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Dr. Samuel Plahner spoke on November 20th at the Grand Avenue Congregational Church on "The Meaning of Life."

On December 5th, Dr. Plahner will address the Milwaukee Women's Club on "Juvenile Criminality," and on January 20th, he will be the principal speaker at a meeting of the West Allis Women's and Mothers' Clubs. His subject at that time will be "The Importance of Psychological Advice for Children At Home and In School."

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Dr. E. L. Miloslavich addressed the Inter-City Meeting of the Rotary Club on October 4th, at Berlin, on "Scientific Investigation of Crime Problems."

On October tenth, Dr. Miloslavich gave an illustrated discussion on "Biological and Pathological Aspects of Crime," before the joint meeting of the Professional Men's and Women's Clubs of Cudahy and South Milwaukee.

The second of a series of postgraduate medical courses being sponsored by the Educational Committee of The Medical Society of Milwaukee County, —"Postgraduate Course in Dermatology,"—held its first session on Monday evening, November 7th, at the Milwaukee Academy of Medicine. The course was opened by Dr. William Allen Pusey, a former president of the American Medical Association, and Professor Emeritus of Dermatology at the University of Illinois College of Medicine, whose subject was "Eczema: Its Fundamental and Practical Aspects."

Following Dr. Pusey's address those enrolled for the course were assigned to the following instructors:

Drs. O. H. Foerster, S. M. Markson, R. G. Washburn, C. A. Baer, H. R. Foerster, L. M. Wieder, M. J. Reuter.

The following physicians enrolled for the course:

Drs. Nat Goldberg, A. I. Greenberg, G. J. Gumerman, H. P. Haushalter, E. B. Gute, Edgar Habeck, E. T. Harrington, J. F. Haug, E. C. Heifetz, G. H. Hoffman, E. Jackson, F. R. Janney, W. M. Jermain, G. J. Schweitzer, H. W. Johnson, L. W. Juergens, C. D. Jurss, A. L. Kastner, P. M. Kauth, A. H. Heidner, A. H. Kundson, S. E. Kohn, G. A. Kriz, Bernard Krueger, A. S. Kult, A. F. Kusterman, D. H. Lando, Jr., H. S. Smith, T. F. Laughlin, A. L. Suhr, S. Spilberg, L. P. Stamm, F. J. Stirn, W. L. Stranberg, L. A. Van Ells, P. C. Wagner, J. C. Zuercker, Bruno Warschauer, N. J. Wegmann, W. F. Weingart, M. E. Wiese, R. P. Wiesen, S. H. Wolter, W. P. Zmyslony, P. E. Aszman, D. C. Ausman, H. R. Ausman, H. E. Bardenwerper, K. T. Bauer, B. Bender, L. A. Bernhard, M. C. Borman, P. L. Callan, S. E. Coffey, E. F. Cook, J. G. Curtin, N. F. Dettman, J. J. McGovern, R. W. Benton, F. E. Drew, J. R. Dundon, L. A. Eisenberg, Norbert Enzer, T. F. Fitzgibbon, J. B. Ozonoff, W. J. Fleming, R. H. Frederick, A. H. Fromm, R. W. Garens, Marian Lewis, E. O. Gertenbach, L. T. Gilmer, B. Lieberman, T. J. Aylward, B. J. Malnekoff, H. B. Miner, Elmer Gramling, W. J. Murphy, W. V. Nelson, E. F. Peterson, G. W. Neilson, P. J. Niland, P. E. Oberbreckling, E. B. O'Leary, Maurice Olsen, P. H. Perlson, M. G. Peterman, W. B. Walton, D. F. Pierce, C. C. Reinke, G. J. Pugh, E. P. Bickler, R. T. Rank, J. A. Russell, W. A. Ryan, E. J. Schelble, L. J. Schneeberger, H. F. Scholz, H. S. Schumacher, W. J. Scollard, S. J. Seeger, L. D. Smith.

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Dr. Elisabeth Seiler lectured to the Randall School P. T. A., at Waukesha, on "House and Habit Training" on October 18th, at seven-thirty. One hundred fifty parents attended.

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Dr. Eugene C. Heifetz addressed the round table group at the Jewish Center on November 22nd. His subject was, "Our Morality and Where It Fails."

"The Psychology of Fear," was the subject of Dr. Edward N. Schoolman's address before this same group.

Dr. Nathan Sinai, professor of hygiene and public health at the University of Michigan Medical School, will speak on "Panel Medicine and Dentistry" at the New Marquette Medical School Auditorium at 8 P. M., on December 14th.

Dr. Sinai, in collaboration with Mr. A. M. Simons, is the author of "The Way to Health Insurance."

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Dr. George V. I. Brown was the principal speaker at a meeting of the Professional Men's Club on November 14th. Dr. Brown's talk, which was illustrated, described the progress that has been made in plastic surgery.

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During the second week in November, Dr. F. J. Gaenslen gave a postgraduate course in traumatic surgery at the University of Oklahoma, Norman, Oklahoma. It was Dr. Gaenslen's second appearance on the university's course. A lecture given by Dr. Gaenslen on November 12th was attended by 300.

The Oklahoma institution has manifested a keen interest in the postgraduate work being done under the auspices of the educational committee of The Medical Society of Milwaukee County, and has written the executive office of the Society for specific details regarding the manner of presentation of the courses given by the Society, which have been most successfully concluded.

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The third of a series of postgraduate courses,—"Postgraduate Course In Roentgenology,"—opened on December 5th, with Dr. Arthur W. Erskine, Ex-President of the Radiological Society of North America, of Cedar Rapids, Iowa, as the speaker.

These courses have aroused wholehearted enthusiasm among the membership of the Society, and the attendance at all sessions had been excellent.

The following courses are still to be given during the 1932–33 session:

"Postgraduate Course in Eye, Ear, Nose, and Throat;" "Postgraduate Course in Gynecology and Obstetrics;" "Postgraduate Course in Urology."

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Dr. and Mrs. George E. Whalen, who have been in Europe for the past several months on their wedding trip, landed in New York on November eighth. After spending a few days in New York they returned to Milwaukee.

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Miss Jane Stratton, daughter of Dr. and Mrs. Frederick A. Stratton, and Hugh J. Helmer, son of Mrs. Genevieve Helmer of Pontiac, Michigan, were married on November 23rd at the home of the bride's parents.

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Mr. Theodore Wiprud, executive secretary of The Medical Society of Milwaukee County attended the conference of State Medical Society Secretaries in Chicago on November 18th and 19th.

Dr. and Mrs. Ralph Sproule, who have spent several months abroad visiting France, Switzerland, England, and Italy, returned to Milwaukee in time to spend the Thanksgiving holidays with their family.

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Dr. John L. Yates spent a few days in Rochester, New York, during the early part of November.

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Mrs. Frank E. Darling, Jr., and son left on November the 18th for Philadelphia where they will join Dr. Darling who is engaged in postgraduate study at the University of Pennsylvania Medical School.

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Mrs. Caroline Wilk Kleinboehl, mother of Dr. Julius Kleinboehl, died on November the 9th, at the age of 83 years.

Mrs. Kleinboehl lived all of her life in and near Milwaukee, having come here sixty-five years ago from Cedarburg.

Surviving Mrs. Kleinboehl besides her son, Dr. Julius, are a daughter, Mrs. M. J. Brew, and a son, Arthur L., both of Milwaukee.

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Dr. E. B. Gute, health commissioner of Whitefish Bay, spoke at the Parent-Teacher Association of the Henry Clay School on November 21st. Dr. Gute presented the school health program as outlined by his department.

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At the last annual meeting of the board of trustees of the Inter-State Postgraduate Medical Association of North America (October 23, 1932), Dr. Edwin Henes, Jr., the executive secretary of the Association, requested that he be relieved of all his duties and responsibilities in connection with his conduct of the affairs and business of the Association. Dr. Henes had completed a decade of service to the Association, during which time he assisted in the arrangement for, and presentation of, ten international assemblies.

During those ten years, with the help and guidance of the officers and the board of trustees, and the managing director, and on their authority, Dr. Henes devoted his attention particularly:

To arranging for the assemblies, and the careful registration of those in attendance;

To the building up and the complete conduct of technical and scientific exhibits;

To the editing and publishing and distribution of the proceedings or transactions of the assemblies; and

To the duties that are usually included in the positions of secretary and executive secretary of an association.

The board of trustees, in accepting Dr. Henes' request, unanimously passed the following resolution:

"Resolved: That the thanks of the entire board of trustees and officers of the Association be extended to Dr. Edwin Henes, Jr., for his very efficient and businesslike services as secretary, and that this board very much regrets that the condition of his health prevents his continuing his work at this time. The board fully realizes, and highly appreciates the untiring efforts he has put forth in helping the board to build up this organization to the enviable position it has attained".

The affairs and business of the Association will be continued under the guidance of the same board of trustees, and under the management of Dr. William B. Peck. The activities and duties formerly merged in Dr. Henes' office will, in the future, be taken care of by the following members of the board of trustees:

Secretary and in charge of registration:
Dr. Tom B. Throckmorton, 936 Bankers' Trust Building, Des Moines, Iowa;

Director of Exhibits:
Dr. Arthur G. Sullivan, 613 Gay Building, Madison, Wisconsin;

In Charge of Publications (Proceedings):
Dr. William B. Peck, Freeport, Illinois.

Dr. Henes will lend his full support and co-operation in an advisory and co-ordinating capacity to the group now actively concerned with the work, purposes, and ideals of the Inter-State Postgraduate Medical Association of North America.

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Dr. Fenton Benedict Turck, son of the late J. Byron Turck and Sarah Ashby Turck, early Milwaukee settlers, died at his home in New York early in November.

Dr. Turck was born in Milwaukee in 1857, received his early education at Markham's Academy here, and was graduated from the Chicago Medical College.

Prior to serving as director of the research laboratories of the Turck Foundation in New York, Dr. Turck was a professor of internal medicine at the Post Graduate Medical School and home surgeon of the Alexian Brothers Hospital, Chicago. He was a fellow in the New York Academy of Medicine, a member of the American Medical Association and of the Chicago Academy of Medicine. He was nationally-known research biologist and physician.

Surviving Dr. Turck are his widow, Mrs. Avis Turck and two children.

BIRTHS

A daughter to Dr. and Mrs. Armin Steckler, Milwaukee, on October 23rd.

A son to Dr. and Mrs. L. W. Hipke, Milwaukee, on October 24th.

A daughter to Dr. and Mrs. Mark Bach, Milwaukee, on November 12th.

A daughter, Charlotte Rita, to Dr. and Mrs. Julian Y. Malone, Milwaukee, on November 13th.

ENGAGEMENTS

Dr. Rudolph J. Noer, Madison, formerly of Wabeno, to Miss Anita Showerman, Madison.

MARRIAGES

Dr. Joseph A. Russell, Milwaukee, to Miss Catherine Nagle, at Oconto on October 29th.

Dr. C. W. Aageson, Madison, to Miss Alma Docken, Madison, at Nashua, Iowa on October 20th.

DEATHS

Dr. Charles Gorst, Madison, died on November 7th at a Madison hospital following an illness of several weeks.

Dr. Gorst was born September 15, 1853, in Black Earth, Dane County. He was graduated from the College of Physicians and Surgeons, Keokuk, Iowa, in 1879. After graduation, he practiced for several years in Lime Springs, Iowa. In 1884 he moved to Baraboo, where he remained for eighteen years. While a resident of Baraboo, Dr. Gorst was interested in many civic and industrial enterprises. He was active in promoting the project of the state park at Devils Lake. He also served at various times as county physician and for fifteen years was city health officer.

In 1904, Dr. Gorst was appointed superintendent of Mendota State Hospital for the Insane. During his period of supervision, the hospital was placed under a ten-year plan of development which gave it a training school for nurses, a psychiatric research laboratory, and a contagious hospital. Through Dr. Gorst's efforts, a chair of psychiatry was established at the University of Wisconsin Medical School.

In 1915, Dr. Gorst retired from the staff of Mendota State Hospital, and in 1918 served as director of health and sanitation for the Mobile Shipbuilding Company, Mobile, Alabama, and after the armistice came to Madison, where he has since resided.

Dr. Gorst was an honorary member of the Dane County Medical Society, the State Medical Society, and the American Medical Association.

He is survived by his widow and one daughter.

Dr. A. T. Johnson, Sauk City, died on October 29th at his home in Sauk City after an illness of more than a year.

Dr. Johnson was born April 3, 1890, in Oconomowoc. He graduated from Marquette University School of Medicine in 1916 and served internship at St. Mary's Hospital, Madison. With the exception of eighteen months' war service at home and overseas, Dr. Johnson practiced his profession at Sauk City. For five years after the war he acted as radiologist at St. Mary's Hospital in Madison and served on its medical staff up to the time of his death.

His overseas war service included assignments with Mobile Surgical Unit 541; medical officer for Russian prisoners at Sebastopol Barracks; with the 53rd Pioneer Infantry (N. J.) as medical officer, and officer in charge of hygiene and sanitation of Pershing Stadium.

Dr. Johnson was a member of the Sauk County Medical Society, the State Medical Society, and was a fellow of the American Medical Association.

He is survived by his widow, one son and two daughters.

He was buried with military honors.

Dr. Henry Nolte, Milwaukee, died on November 11th at his home in Milwaukee.

Dr. Nolte was born in the year 1873 and was a graduate of Columbia University College of Physicians and Surgeons, New York City in 1898. He had practiced in Milwaukee since graduation.

Dr. Nolte is survived by his widow.

Dr. F. T. Riley, Milwaukee, died on November 6th at his home. He had been ill for four weeks.

Dr. Riley was born in Indiana in 1854 and received his medical education at the Medical College of Ohio, Cincinnati, in 1877. Following graduation, he practiced in Kentucky. In 1895 Dr. Riley came to Chicago where he remained four years before coming to Milwaukee.

He is survived by one son and one daughter.

Dr. D. C. Cavanagh, Montello, died on October 24th at his home in Montello, following a long illness.

He was born in the year 1868 and graduated from Rush Medical College in 1895. He had practiced in Montello since that time.

Dr. Cavanagh is survived by his widow.

Dr. William Wegge, Jr., Milwaukee, died on November 3rd at Milwaukee County Emergency hospital.

Dr. Wegge was born in the year 1891 and was a graduate of Rush Medical College in 1918. He had practiced in Milwaukee up to the time of his death.

He is survived by his parents.

SOCIETY RECORDS

New Members

N. A. Hill, 1 South Pinckney St., Madison.
Emmett A. Meili, Cochrane.
Chas. F. Burke, 113 N. Carroll St., Madison.
Edward McCormack, Niagara.
James D. Casey, Menasha.
H. H. Hull, North Fond du Lac.
D. F. Cole, Ripon.
J. A. Sanford, South Milwaukee.

Changes in Address

Arthur Kovacs, Milwaukee to Christoph Building, Waukesha.

Sarah I. Morris, Madison to 505 Old Forest Road, Carroll Park, Philadelphia, Pa.

H. L. Jorgenson, Kenosha to 1531 Main St., Marinette.

E. H. Lechtenberg, Potosi to Cassville.

Special Council Meeting Votes Active Opposition to Examining Clinic of Employers Mutual Liability Insurance Company

A so-called Examining Clinic which will give pre-employment and periodic examinations to potentially upwards of 7,000 employees in the metal trades in Milwaukee, established and financed by the Employers Mutual Liability Insurance Company of Wausau, met with the active opposition of the Council of the State Medical Society of Wisconsin following an all day special meeting on November sixth.

The "Wausau Mutual" is the same company that caused the introduction of a bill in the 1931 legislature providing that nurses in industrial plants should be exempt from the provisions of laws establishing standards for treating the sick that such nurses might administer not only first aid and apply dressings but might prescribe "family remedies and medicines allowed by law to be sold without a prescription, for injured or sick employees or to their immediate families." The bill was killed.

Under the newly formed Examining Clinic sponsored by the same insurance company, it is the announced intent to form a corporation of employers to hire a physician or physicians who would conduct pre-employment and subsequent examinations under the direction of the lay group. Obviously if laymen can group together to hire a physician whose services for diagnostic purposes are to be re-sold, it will likewise be possible for the same group or corporation, or any other group of laymen to enlarge the plan to comprehend other services in treating the sick and injured.

The announced purpose of the clinic is to protect employers and the insurance company from the very large bills resulting from an increased number of silicosis claims and to protect workingmen from silicosis. The clinic is modeled after a somewhat similar organization at Picher, Oklahoma, presently run by mine operators, at which the costs per examination, including blood Wassermann and one 11 by 14 flat x-ray film, have been reduced to under two dollars.

A long effort by the Council to secure a change in the announced policy to permit of the use of local facilities and local physicians capable and willing, under conditions that would not provide for direct control of their work, met with no success. Representatives of the Insurance company declared that operation of the clinic would only be successful from the point of view of the information desired by the employer and cheapness of medical service, under the plans announced by them. That the service so organized might be extended to other cities was admitted to be a possibility.

Advocates of the plan stated that interested employers insured with the Wausau company constitute the members of a corporation. This corporation, acting under the financial backing of the insurance company, will sell examinations of employees for $3 each to employers insured with the Wausau Company and at $5 each to employers not so insured. No information will be given to the employee by the examining physician other than that when he finds conditions warranting medical service he will state, without disclosing what has been found, that he will be glad to give his findings to the family physician. Employers, on the other hand, will receive a code indicating whether the employee is a desirable physical risk in his present occupation. It was contended that where physical examinations indicated the advisability of the procedure, the man would not be discharged but his occupation would be "shifted" to one less hazardous. It was admitted, on the other hand, that comparatively little shifting of employment to avoid dust could be accomplished in most foundries under their present set-up. It was suggested that the plan might actually work out not only to deprive a man of his trade but to do so with all employers taking advantage of the clinic plan, and upon the result of what might prove to be but a partial physical examination by but one physician. In other words, the usual relationship between physician and patient would be ignored and disregarded for the purposes of the clinic.

OPPOSITION VOTED

After an all day session, representatives of the insurance company indicated their willingness to meet with a committee of the Council to iron out basic differences. The Committee found, however, that the company was adamant and as a result the Council voted to support the Medical Society of Milwaukee County and actively oppose the Clinic on the grounds:

1. Its organization, whether or not by actually incorporating, provides for the lay supervision of the practice of medicine,—a condition which the Council holds is neither in the public interest nor in conformity with the laws of the state.

2. To the examined person, his examination likely will appeal to him as constituting an actual complete periodic health examination. It may or may not be such, and probably will not be true inasmuch as cheapness of service is the essence of the plan.

3. The relationship of physician to patient will not exist. To support a plan lacking such relationship would place the profession in the position of approving a procedure in which a workingman—patient who had incurred an occupational disease might not be advised directly of the fact or of his rights.

4. Insofar as the plan contemplates advising the employer of the condition of the applicant, even though in generalities by use of a code, physicians cannot support any such measure which might well result in depriving patients of the opportunity to follow their trade throughout a given industrial center, without definite assurance that:

a. The employee-patient knows exactly what the physician is doing and approves such procedure in writing.

b. No report will be made to any employer in questionable cases until and unless a sufficiently comprehensive examination has been made to insure against what might easily be, under such a plan, a grave injustice to the employee-patient.

That it was anticipated that the proposed set-up of the clinic would bring disapproval of the medical profession was admitted by a representative of the insurance company who stated that the plan had been kept a secret for the better part of a year until it could be announced as being under way. The company had further secured an advisory committee of physicians but in terms of one representative, the main purpose of this committee was "to sell the profession".

To make its opposition effective, the Council has directed certain officers to bring the position of the profession to the attention of all affected including the Surgeon General, the Industrial Commission of Wisconsin, and others.

Majority and Minority Report for Final Recommendations of Committee on Costs of Medical Care; Reports Summarized

Through the kindness of the Editor of the Journal of the American Medical Association, the following material from the issue of December 2nd, was furnished in advance that we might present this authoritative and carefully prepared digest. We commend it to our readers for careful study.

Five years of work by the fifty members and research staff of the Committee on the Costs of Medical Care have culminated in this final report, entitled "Medical Care for the American People." The majority report was favored by the following:

Private Practice.—Lewellys F. Barker, M. D.; Walter P. Bowers, M. D.; J. Shelton Horsley, M. D.; Stewart R. Roberts, M. D.; Richard M. Smith, M. D.; Walter R. Steiner, M. D., and Rollin T. Woodyatt, M. D.

Institutions and Special Interests.—W. Irving Clark, M. D.; William Darrach, M. D.; Louis I. Dublin, Ph. D.; Elizabeth Fox, R. N.; Ambrose Hunsberger, Phar. M.; Alfred Owre, D. M. D., M. D.; W. S. Rankin, M. D.; Mary M. Roberts, R. N.; Alphonse M. Schwitalla, Ph. D., and Winford H. Smith M. D.

Public Health.—George H. Bigelow, M. D.; Herman N. Bundesen, M. D.; Haven Emerson, M. D.; John Sundwall, M. D., and C. E. A. Winslow, Dr. P. H.

Social Sciences.—Michael M. Davis, Ph. D.; William T. Foster, Ph. D.; Wesley C. Mitchell, Ph. D.; William F. Ogburn, Ph. D., and Henry C. Taylor, Ph. D.

The Public.—Winthrop W. Aldrich; Morris L. Cooke, D. Sc.; Mrs. William Kinnicutt Draper; Homer Folks, LL. D.; John P. Frey; Mrs. Walter McNab Miller; William J. Schieffelin, Ph. D.; Amelia Sears, and Ray Lyman Wilbur, M. D.

MAJORITY REPORT

A summary of the majority reports follows:

I

"The Committee recommends that medical service, both preventive and therapeutic, should be furnished largely by organized groups of physicians, dentists, nurses, pharmacists and other associated personnel. Such groups should be organized, preferably around a hospital, for rendering complete home, office and hospital care. The form of organization should encourage the maintenance of high standards and the development or preservation of a personal relation between patient and physician.

II

"The Committee recommends the extension of all basic public health services—whether provided by governmental or nongovernmental agencies—so that they will be available to the entire population according to its needs. This extension requires primarily increased financial support for official health departments and full-time trained health officers and members of their staffs whose tenure is dependent only on professional and administrative competence.

III

"The Committee recommends that the costs of medical care be placed on a group payment basis, through the use of insurance, through the use of taxation, or through the use of both these methods. This is not meant to preclude the continuation of medical service provided on an individual fee basis for those who prefer the present method. Cash benefits, i. e., compensation for wage-loss due to illness, if and when provided, should be separate and distinct from medical services.

IV

"The Committee recommends that the study, evaluation and coordination of medical service be considered important functions for every state and local community, that agencies be formed to exercise these functions, and that the coordination of rural with urban services receive special attention.

V

"The Committee makes the following recommendations in the field of professional education: (A) That the training of physicians give increasing emphasis to the teaching of health and the prevention of disease; that more effective efforts be made to provide trained health officers; that the social aspects of medical practice be given greater attention; that specialties be restricted to those specially qualified; and that postgraduate educational opportunities be increased; (B) that dental students be given a broader educational background; (C) that pharmaceutical education place more stress on the pharmacist's responsibilities and opportunities for public service; (D) that nursing education be thoroughly remolded to provide well educated and well qualified registered nurses; (E) that less thoroughly trained but competent nursing aides and attendants be provided; (F) that adequate training for nurse-midwives be provided, and (G) that opportunities be offered for the systematic training of hospital and clinic administrators."

The first chapter surveys "The Present Status of Medical Care." It reports that 177,000 physicians and dentists, with some 900,000 others at an annual expense of $3,647,000,000, so distribute their services that those in the lower income groups, while suffering as much or more sickness, receive far less medical service than those with a greater income.

There is a lack of preventive health care; indeed, "niggardly appropriations for public health work." The burden of sickness cannot be measured by averages, because of the extreme unevenness with which it is distributed. Fifty per cent of the families in the United States have incomes of less than $2,000 which means that "even less-than-average charges for medical service, therefore, are more than many of our families can bear."

One conclusion reads: *"Certainly no solution to the problems of medical costs can be reached through a reduction in the average of professional incomes"* (italics in original). This average is none too high now to attract a high type of practitioner and permit progress through graduate training and study.

The Committee attempts from the report of some of these investigations to calculate the cost of complete medical care and concludes that "all needed medical care of the kind which people customarily purchase individually could be provided in urban regions at least, at a cost, excluding capital charges, of $20 to $40 per capita per annum."

ESSENTIALS OF SERVICE

The second chapter discusses "The Essentials of a Satisfactory Medical Program." Six basic essentials are enumerated:

"1. The plan must safeguard the quality of medical service and preserve the essential personal relationship between patient and physician.

"2. It must provide for the future development of preventive and curative services in such kinds and amounts as will meet the needs of substantially all the people and not merely their present effective demands.

"3. It must provide services on financial terms which the people can and will meet, without undue hardship, through either individual or collective resources.

"4. There should be a full application of existing knowledge to the prevention of disease, so that all medical practice will be permeated with the concept of prevention. The program must include, therefore, not only medical care of the individual and the family but also a well organized and adequately supported public health program.[1]

"5. The basic plan should include provisions for assisting and guiding patients in the selection of competent practitioners and suitable facilities for medical care.

"6. Adequate and assured payment must be provided to the individuals and agencies which furnish the care."

Having set up these standards, the Majority Report selects three lines of approach to the solution of its problem:

"*(a)* The development of types of organized or group practice that will more effectively and economically meet the community's medical needs.

"*(b)* The distribution, over a period of time and over a group of families or individuals, of the costs of service.

"*(c)* Provision for the planning and coordination, on a local and regional basis, of all health and medical services."

It is evident that the program of the Majority Report centers around "provision of service through organized groups." The groups studied on which conclusions are based covered only fifty such groups; conclusions as to the financial operation of such clinics and especially as to their net and gross income are based on the information furnished by twenty-seven such clinics.

The Majority Report sets up "standards" for group practice and among these emphasizes the statement that "*lay groups organized for profit have no legitimate place in the provision of this vital public service*" (italics in original). This standard, the Committee seems to fail to note, would eliminate many of the examples of group practice on which it depends for the argument previously mentioned leading to the estimate of annual cost.

"Inevitably the Committee has been led to the conclusion that the costs of medical care should be distributed over groups of people and over periods of time." This leads to the adoption of insurance as a major recommendation. The participation of insurance companies is rejected and taxation accepted only in a secondary form. Having eliminated these, the Majority Report is brought to the somewhat indefinite conclusions that "there should, therefore, be an agency in each community through which the lay and the professional groups concerned in providing and financing medical services could consult, plan and act in behalf of the best provision of medical resources which the community can afford." The character of this "agency" remains indefinite throughout the report.

Chapter three sets up "An Ultimate Objective in the Organization of Medicine." "The keystone of the concept of a satisfactory medical service for the nation is the development of one or more non-profit 'community medical centers' in every city of approximately 15,000 population or more." Then follows a description of such an imaginary center. The Majority Report passes lightly over such questions as the possibility of the redistribution of great medical centers that have been established in most large cities for educational, political, financial or other purposes which render them ill adjusted to fit into such a program.

It assumes that existing hospital organizations can be so transformed but offers little information as to the methods by which this change may be brought about. There is much talk of "coordination and control of services" but there is no definite statement as to what is to constitute this important factor in the program.

Chapter four considers "Plans and Experiments Now Under Way" and lists twenty-five such experiments. Four of these are "under professional sponsorship"; four "under consumer sponsorship"; thirteen are listed as "under community sponsorship with professional participation"; one "under joint sponsorship of professional and consumer groups," and three "under commercial sponsorship." All of these are treated without the specific criticisms necessary to inspection of the foundation stones on which the structure of the national medical service is to be erected.

The Committee concludes that:

"These twenty-five types of development in the United States and the many developments abroad show a ferment at work in medical practice which contains great possibilities for good and evil. The Committee is aware of the fact that some of the plans are mere attempts to capitalize for private gain the people's need for better medical service. It is equally aware of the dangers inherent in other plans. Each should be viewed as an experiment and subjected to the careful evaluation that is given in a scientific laboratory. Some of them appear to the Committee to be very promising."

The fifth chapter includes "The Recommendations of the Committee" previously here quoted. The somewhat vague character of the report is excused by the statement that "the committee believes that its obligations require it to think ahead for twenty or thirty years, as well as for the next five or ten years and to present distant as well as immediate goals."

(Continued on page 876)

[1] The term "public health program" is meant to include the work of the official health departments and of voluntary health agencies.

PRESS SERVICE OF STATE MEDICAL SOCIETY

No serum does so much for public health as printer's ink

HEART DISEASE

Madison, Wis., Nov. 3.—Heart disease has been taking an increasing toll in Wisconsin. The death rate from heart disease in the State in 1908, when the first complete reports of deaths were collected, was 95 out of every 100,000 living in Wisconsin at that time. For 1931 this rate had increased to 202.8 per cent. This shows that the death rate from heart disease has increased more than 200 per cent in the last 24 years. The highest rate in the state was obtained in 1929 when 6,200 people died of heart disease and the rate that year reached 213.2 per cent.

The relative reports of heart disease as the cause of death shows that for each 100,000 persons living in Wisconsin in 1931, while 6,024 died of heart disease in some form, 3,495 died of cancer and 2,562 of cerebral hemorrhage.

The rapid increase in deaths from heart disease is due, in part, to the American ways of living, according to the bulletin issued by the Educational Committee of the State Medical Society today.

"Everybody is in too much of a hurry," declares the bulletin, "everybody is rushing as if they had only two minutes to get to the place.

"Habits of right living which our children practice so enthusiastically are gradually but surely being forced on the older members of the family. The result, very naturally, is a marked improvement in health. A few concrete examples of what we mean by 'habits of right-living' may be mentioned. The care of the teeth, sleeping with the windows open, moderation in eating, exercise in the open air, an annual physical examination, and many other practices of a similar nature may be mentioned as valuable aids in safeguarding health.

"There never has been a time in the history of our country when people generally have had so many exposures to good health as at present. Newspapers and magazines which used to be filled with patent medicine advertising now contain vast quantities of practical advice on how to keep well. The vicious circle sickness causing poverty and poverty as a contributing cause of illness is gradually but surely being broken. The great advances in surgery during the last twenty years have also been an important factor in prolonging the lives of many thousands of persons who otherwise would have died.

"Another element relating to lack of health education must also be mentioned. Health agencies, both official and voluntary, in the past have devoted most of their time and energy to the prevention and control of communicable diseases, such as typhoid fever, diphtheria and tuberculosis, and very little attention was given to heart disease, cancer or diabetes. It is not strange, therefore, that little progress has been made in the prevention or treatment of these diseases.

"It requires no proof that more people are now living to be fifty years of age or older than ever before. This is recognized by everyone who has made a study of deaths by age groups. The increased mortality from heart disease, therefore, is not so alarming as it appears. In extreme old age an actual reduction in the death rate from heart disease can only mean a corresponding increase in the rate from other causes of death characteristic of advanced years. We all must die, but it is our aim to postpone our going as long as possible."

* * *

BAD TEMPER

Madison, Wis., Nov. 10.—Many a man has missed a good job because of the temper which, as a child, he exhibited in the nursery.

"Bad tempers and sullen behavior cost more people their places in the world of affairs and their esteem in society despite all their brilliance and learning," declares the Educational Committee of the State Medical Society in a bulletin issued today.

"Mothers should correct two habits of children:

1. Crying in order to get their own way.
2. Sulking until its requests are granted.

"Now is understood better than before the enduring influence of habits that begin in the earliest years of life, in the nursery, or even in the cradle," declares the bulletin. "In the young child, as a result of habit, certain types of behavior, or patterns of behavior, become established which continue throughout life. Later, these behavoir patterns can be modified by training but cannot be wholly eradicated.

"Perhaps the child had learned, while yet an infant, that he could get what he wanted if he cried loud and long enough. Perhaps he had learned, when a little older, that bad behavior as tantrums, screaming, rolling on the floor or sulking, brought him what he wanted after his request had been refused or ignored.

"If he had this experience once, you may be sure he would repeat the action when next the occasion arose. Soon it would be a pattern of behavior appearing whenever his wishes were opposed. When older he will not scream but he will be angry and resentful.

"If, in the beginning, it had been that bad behavior had gained him nothing and he could have had his wish, if at all, only by good behavior, the child would have seen that anger was useless and that particular pattern of behavior would not have become fixed.

"Other patterns of behavior, good as well as bad, are formed in imitation of older children and adults. Not having yet acquired reason and judgment the small child is uncritical; he openly imitates all that he sees and hears of the actions of older people. In this way many likes and dislikes, tastes and ambitions, which in later years become crystalized into character traits, have their beginning. Calmness and poise as well as nervous and panicky behavior in the presence of an emergency, are nothing more than behavior patterns established by imitation and made permanent by repetition. The elders are responsible, far more than they realize, for the conduct of the children in the family."

* * *

THE COMMON COLD

Madison, Wis., Nov. 17.—The danger flag of warning was sent out this week by health authorities advising people of the perils that lurk in common colds. With the closing of windows and the use of the furnace in the homes of Wisconsin during the past two or three weeks, a regular epidemic of colds has occurred throughout the state. To meet this situation, the State Board of Health recently issued a report on common colds, causes and dangers, which will be sent free upon request.

"The virus of the common cold is lurking in almost every Wisconsin nose, and failure to keep up a high degree of physical resistance will allow it further ingress," declares the Medical Society Bulletin out today.

"Colds are infectious, and are spread from person to person by the excretions of the nose, throat and mouth.

"Colds are serious and should never be regarded as trivial

(Continued on page 872)

THE JOURNAL BOOK SHELF

BOOKS RECEIVED FOR REVIEW

Diagnosis and Treatment of Diseases of the Thyroid Gland. By George Crile and Associates. 508 pages with 164 illustrations. W. B. Saunders Company, Philadelphia and London, 1932. Cloth, $6.50 net.

Erdmann's Clinics. Stenographic reports of the clinics of John F. Erdmann, M. D., professor of surgery in Columbia University; executive officer in the department of surgery, New York Post-Graduate Medical School; director of the department of surgery, New York Post-Graduate Hospital. 315 pages with 39 illustrations. W. B. Saunders Company, Philadelphia, 1932. Cloth $4.50 net.

The Races of Man. Differentiation and Dispersal of Man. By Robert Bennett Bean, M. D., professor of anatomy, University of Virginia. The University Society, 468 Fourth Ave., New York, N. Y.

Anatomy of the Brain and Spinal Cord. By William W. Looney, A. B., M. D., professor of anatomy, Baylor University College of Medicine, Dallas, Texas, with 153 illustrations. Second edition, revised. F. A. Davis Company, Philadelphia, 1932. Price $4.50, net.

Children's Tonsils In or Out. By Albert D. Kaiser, M. D., associate professor of pediatrics, University of Rochester Medical School; chief pediatrician, Rochester General Hospital; pediatrician, Rochester Dental Dispensary. Illustrated. J. B. Lippincott Company, Philadelphia.

Synopsis of Gynecology. By Harry S. Crossen, M. D., professor of clinical gynecology, Washington University Medical School, and gynecologist in chief to the Barnes Hospital and the Washington University Dispensary; gynecologist to St. Louis Maternity Hospital, St. Luke's Hospital, and the De Paul Hospital; and Robert James Crossen, M. D., instructor in clinical gynecology and obstetrics, Washington University School of Medicine. 110 illustrations. C. V. Mosby Company, St. Louis, 1932. Price $2.75.

Clinical Gynecology. By C. Jeff Miller, M. D., professor of gynecology, Tulane University School of Medicine; chief of the department of gynecology of Touro Infirmary; senior visiting surgeon, Charity Hospital, New Orleans. Illustrated. Price $10. C. V. Mosby Company, St. Louis.

Injuries of the Eye. Diagnosis and treatment, forensic procedures and visual economics. By Harry Vanderbilt Wurdemann, M. D., Sc. D., colonel, medical reserve corps; flight surgeon air corps, U. S. Army; medical examiner, aeronautics branch, U. S. Department of Commerce, Seattle, Wash. Price $13.50. With 236 illustrations and 10 color plates. C. V. Mosby Company, St. Louis, 1932.

The Colon, Rectum and Anus. By Fred W. Rankin, B. A., M. D., division of surgery, The Mayo Clinic; associate professor of surgery, The Mayo Foundation; and J. Arnold Bargen, M. D., division of medicine, The Mayo Clinic, assistant professor of medicine, The Mayo Foundation, and Louis A. Buie, B. A., M. D., section on proctology, The Mayo Clinic, associate professor of proctology, The Mayo Foundation. With 435 illustrations. W. B. Saunders Company, Philadelphia, 1932. Cloth, $9.50 net.

BOOK REVIEWS

Any scientific publication reviewed in this col- such inspection should be directed to the Medi- umn may be obtained for inspection. Orders for cal Library Service, 424 N. Charter Street, Madison, Wis.

Principles of Chemistry. By Joseph H. Roe, Ph. D., professor of biochemistry, George Washington University Medical School; lecturer in chemistry, Central School of Nursing, Washington, D. C.; captain, sanitary division, U. S. Medical Reserve. Third Edition, Price $2.50. C. V. Mosby Co., St. Louis, 1932.

Experience, we believe to be the most fundamental part of our learning, and laboratory experience requires much time. It is doubtful whether anything more than the most superficial acquaintance with the broad field of chemistry can be attained in the couse of a year. Nevertheless, where a year is the maximum time allotted to basic sciences, it is necessary to make such contact as worthwhile as possible. This is the pedagogic problem undertaken by Professor Joseph H. Roe, of the department of biochemistry, George Washington University Medical School, in his "Principles of Chemistry", and designed for nurses and students of home economics.

The text covers the fields of general chemistry, organic, and biochemistry, in 336 pages. In addition, Part II consists of a laboratory manual for experimental work. Some idea of the coverage may be obtained by a few of the chapter headings: "The Structure of Matter"; "Solution and Ionization"; "Catalysis, Enzymes, Colloids, Dialysis, Osmosis"; "Metabolism"; "Vitamins"; "Internal Secretions"; "The Chemistry of Excretion".

On the whole Professor Roe has made a surprisingly interesting summary of chemistry for anyone

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with a background of training in this field. The statements are concise and clear. The illustrative material is well chosen from everyday experience. And for the problem which the book is designed to meet, it is probably the best in the field. It will also be found very useful for anyone wishing to refresh his memory on the fundamentals of chemistry.

H. C. B.

Posture: Its Relation to Health. By Frank D. Dickson, M. D., J. B. Lippincott Company, Philadelphia and London.

This is a monograph on posture in its relation to health. It is written for the general practitioner, many of whom have either neglected or failed to realize the important relationship between posture and health.

The author considers among other things such conditions as visceroptosis, posture in children including bow legs, knock knees and flat feet. The chapters on postural backache, arthritis and scoliosis are good. The principles of treatment are clearly defined, practical, and in the main are such as may be carried out by the general practitioner.

The book is recommended for those who have need for a book on such a subject. R. E. B.

Pharmacology of the Medicinal Agents in Common Use. By Stanley Coulter, Ph.D., Sc.D. Published by Eli Lilly & Company, Indianapolis, Indiana.

This manual, published by the Lilly organization, is prepared apparently as a substitute for the manual of the U. S. Pharmacopoeia and National Formulary, published by the American Medical Association.

Admittedly, "In doubtful cases the decision as to inclusion or exclusion has been made after consultation with specialists of the medical and scientific staff of Eli Lilly and Company. It should be kept in mind, however, that in the judgment of the writer, its (a drug's) therapeutic value has not been fully established, and that it is regarded as still in the experimental stage."

The book scarcely deserves the ambitious title of "Pharmacology of the Medicinal Agents in Common Use" but rather presents a concentrated digest of properties and uses of many common drugs.

A. L. T.

MEDICAL BOARD APPOINTED

Governor Philip F. La Follette has announced the appointment of the following physicians to be members of the State Board of Medical Examiners: Dr. A. J. Gates, Tigerton; Dr. A. D. Galloway, Barron; Dr. Henry J. Gramling, Milwaukee, and has reappointed Drs. Robert E. Flynn, La Crosse, and John E. Guy, Milwaukee.

Holdover members of the Board with terms expiring July 1, 1933, are: Drs. T. J. Sheehy, Tomah; Wilbur N. Linn, Oshkosh and E. C. Murphy, Eau Claire, the latter being the osteopathic member.

PRESS SERVICE

(Continued from page 869)

"1. Because in children they may be the onset of one of the communicable diseases such as measles, diphtheria, whooping cough, and others.

"2. Because they may be the ushering in of pneumonia, or other serious respiratory diseases.

"3. Because they may linger and render the parts receptive to infective germs, predisposing to infection by pneumonia.

"4. Because they may extend and infect the middle ear and lead to deafness.

"5. Because they may extend to the sinuses and create a local focus of infection.

"6. Because they may be followed by chronic catarrh.

"7. Because they cause suffering, inconvenience and loss of money.

"If a person contracts a cold it should be treated with respect. He should go to bed, secure rest (and with children this should be followed literally); take a hot foot bath, hot drinks to promote sweating, a purge, and call a physician if at all severe. Children who have a severe cold are not permitted to attend school."

INTERNAL HEMORRHOIDS

(Continued from page 846)

lymphocytic infiltration and a serous exudate; at this time the solution itself has practically disappeared from the tissues. At twenty-four hours the intensity of the lymphocytic infiltration almost approaches that of an impending abscess. After this stage of intense lymphocytic infiltration has been reached, clots usually appear in the venous spaces, and in those cases in which progress is good, the condition within the tissues remains the same for a period of three to five days; then recession begins. Gradually the inflammation subsides and evidences of fibrosis develop. During this time the size of the hemorrhoidal tumor diminishes until, after two to three weeks have elapsed, nothing but an indurated ridge is apparent on proctoscopic examination, and microscopic examination of a removed specimen reveals a mass of fibrous tissue which has replaced the varicosed tumor."

RESULTS

One injection into a bleeding and protruding hemorrhoid is usually sufficient to stop both. Since this is usually the chief com-

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plaint, it is necessary to explain to the patient that the alleviation of these symptoms does not mean he is definitely or permanently cured. It may require two to six injections into a single hemorrhoid to produce a sufficient fibrosis for permanent cure. A single hemorrhoid should not be injected oftener than once a week. Buie gives an injection on each succeeding day, but my plan has been to limit injections to two to three a week. The entire treatment is ambulatory, and patients go about their daily activities immediately following treatment, although I try to plan an injection at a time when they can rest, or take it easy for a few hours afterward. Their usual diet is allowed, and a daily bowel action is encouraged.

COMPLICATIONS

One very strong argument in favor of the injection treatment of internal hemorrhoids is the infrequency of complications, and it is extremely rare to have a serious one. According to Morley's table, based on three thousand cases, pain and secondary hemorrhage occur in one-quarter to one-half percent of the cases. Sloughing of the mucous membrane occurred in two per cent, but it was never at all severe. There was one case of perianal abscess. Embolism is practically unknown. If one will take the time to master the technique even these few complications will be eliminated. Injection which is too low or too freely administered is responsible for most complications. Pregnancy is no contraindication to this form of treatment, until the sixth or seventh month, after which it is advisable to use palliative measures until the pregnancy is terminated.

INJECTION VS. OPERATION

I wish to state that I am not attempting to condemn the various operative procedures now in general use, but the injection method possesses various advantages which cannot be denied. The treatments are painless, or nearly so, as contrasted to severe post-operative pain requiring morphine, and the post-operative pain with defecation. Loss of time from business is not necessary. No hospital expense is incurred. There is no post-operative hemorrhage. No anesthesia is required with its possible sequelae. Operative recurrence is probably less than after injections, but the injections can be repeated if necessary. Yeomans finds a five to fifteen per cent recurrence after five years. Infection is rare, but after operation it is always possible and serious. Possible operative complications, which are practically unknown after injections, are retention of urine, stricture, fecal incontinence, painful skin tabs, fissure, fistula and abscess. There is no mortality after injections, but post-operative fatalities have been reported from hemorrhage, infection and bronchopneumonia.

CONCLUSION

This seems to be in every way a method of treating internal hemorrhoids, which deserves respectful consideration. It is a simple, safe, and satisfactory method, and it can be performed by anyone who will take the trouble to master the technique. It is painless. It is ambulatory. The pathological action, that is, of producing an intra- and extravascular fibrosis in the hemorrhoidal tumor, is a sound one in theory, and in practice works well; so that the injection of internal hemorrhoids may properly replace surgical removal, in the majority of cases.

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MAJORITY AND MINORITY REPORTS

(Continued from page 868)

The Committee's first recommendation that medical service "should be furnished largely by organized groups of physicians, dentists" and so on does not take account of the fact that these groups are already professionally organized in their own associations. Indeed, the existence of these professional associations is almost entirely ignored in the Majority Report.

"The Committee's most fundamental specific proposal is the development of suitable hospitals into comprehensive community medical centers."

Industrial medical service is cited as another step toward the realization of this recommendation, and the Majority Report suggests "that free choice of practitioners should be allowed insofar as practicable."

University medical service is also to be fitted into this scheme. "In 'College towns' it may frequently be feasible to expand the university medical service into a community medical center which serves townspeople as well as students."

The Majority Report recognizes the necessity of measures to maintain the quality of medical service in groups; no recommendations are made concerning relationships with professional associations, the most important bodies for maintaining standards.

INSURANCE PROPOSAL

The recommendation which will undoubtedly attract the most attention is that "the costs of medical care be placed on a group payment basis, through the use of insurance." The discussion is extremely indefinite. The comments interspersed clearly reflect sharp divisions of opinion in the Committee.

It is suggested that "a state medical society might initiate and standardize the organization of group practice in local areas and serve as a negotiating or mediating body in making the arrangements for group payment." On the whole, however, the Majority Report seems to incline to a voluntary insurance scheme with subsidies from taxation.

There is also the conclusion that making "individual practice and not group practice the logical foundation of the whole system . . . has been one of the chief disadvantages which European countries have faced under compulsory insurance." Examples or evidence in support of this conclusion are not made available.

The Majority Report persistently emphasizes the importance of groups; it looks on insurance "as the most effective possible stimulant to the formation of such groups." It is hard to determine whether the groups are to be the basis or the objective of the program.

Confronted with the problem of the "control of competition," which has hitherto evidently produced deterioration in most of the schemes of contract practice which are discussed, the Majority Report proposes the following devices for its control:

> "*(a)* Provision of medical service in increasing proportions by organized non-profit groups with community backing and control.
>
> "*(b)* State regulation of the finances to assure actuarial soundness.
>
> "*(c)* The formulation of general standards and policies, the regulation of charges, and the arbitration of difficulties by the state medical and dental societies or by an officially appointed medical board nominated in large part by the societies."

The Majority Report urges a study by professional groups with lay participants as a preliminary to the installation of any program.

In the final chapter, "The Challenge of the Future," appears recognition of the place of such professional associations. The report says:

> "The cooperation of the professional groups in community or state leadership is essential. Their stake in these issues is very large; their interest is continuing. They should instigate as well as guide. The crucial point in the generalship of the forces at work is, perhaps, the development of a proper relation between the professional and the lay groups. The public should recognize the central place of the professional groups in determining standards and methods. The professions should recognize their ultimate responsibilities to the public. The control of undesirable commercial enterprises in this field will depend largely on the watchfulness of the professional bodies, on their ability to enlist lay cooperation, and on the development of sound and successfully operating non-commercial plans.
>
> "Continued study of the complex problems of medical economics is of the first importance. The Committee's investigations have opened a way. Fortunately, professional societies are establishing bureaus and committees on medical economics. Because a university has the unique advantage of having both medical and social scientists in one organization, the Committee has formally recommended to the universities of the country that they conduct research in this field."

Minority Report

Two minority reports and two statements constitute the views of those members of the committee who found themselves in conflict with the general tone or trend of the majority report.

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FIRST MINORITY REPORT

The first minority report, which was signed by A. Christie, M. D., George E. Follansbee, M. D., M. L. Harris, M. D., Kirby S. Howlett, M. D., A. C. Morgan, M. D., Olin West, M. D., Robert Wilson, M. D., and N. B. Van Etten, M. D., draws attention to the failure of the Committee to show by facts that "organization" can accomplish what is claimed for it in the majority report. There is nothing in the experience of the medical profession to show that the "Community Medical Center" is a workable scheme or that it would not contain evils of its own which might be worse than the evils it is supposed to alleviate. This Medical Center Plan is suggestive of the great mergers in industry in which mass production and centralized control are the principal features. It apparently disregards the fundamentals which make medicine a personal service and which require that the individual patient and not diseases or economic classes or groups be the object of medical care.

The objections to the Medical Center Plan are summarized as follows:

1. It would establish a medical hierarchy in every community to dictate who might practice medicine there.

2. It would be impossible to prevent competition among the many such centers necessary for large cities; cost would inevitably be increased by the organization necessary to assign patients to the various centers. This would add to the evils of medical dictatorship those of a new bureau in the local government with its attendant cost.

3. Continuous personal relationship of physician and patient would be difficult if not impossible under such conditions.

In the opinion of this minority group, the question of "Industrial Medical Service" has not been adequately or fairly dealt with in the majority report. For each of the favorable reports published (publications Nos. 5, 18 and 20) many instances could be cited wherein the results of industrial medical services have been exceedingly unfavorable. It is pointed out that in industrial medical services, mutual benefit associations, so-called health and hospital associations, and other forms of contract practice, no means have been found to prevent destructive competition between individuals or groups concerned with these movements. The studies published by the Committee show only the favorable aspects. They were selected because they were considered the most favorable examples of this type of practice in the United States. For each of these plans a score of the opposite kind can be found.

Utilization of subsidiary personnel is nothing new in medical practice. Already there is constant temptation in many fields to permit technicians to perform duties entirely unjustified by their knowledge and training. The minority expresses a word of caution relative to the dangers involved in permitting non-medical technicians to assume the duties which only physicians should undertake.

The Committee's first recommendation that medical service "should be furnished largely by organized groups of physicians, dentists" and so on is apparently predicated on the Committee's study on "Private Group Clinics." This minority group believes that the establishment of such clinics is in line of progress when they are a natural outgrowth of local conditions, but the studies published by the Committee, in the opinion of the minority, were far too few in number to constitute a safe base on which to erect so large and revolutionary a structure as is proposed. The majority report fails to consider the fact that multiplication of clinics or groups in large communities results in duplication of expensive equipment far beyond the needs of the community. Such a multiplication of medical facilities, instead of reducing overhead and the costs of medical care to the community, adds to this cost through the duplication of plants. It is significant to note that the overhead in private medical practice averages only about 2 per cent higher than for medical groups in the lower brackets of gross income. As the gross income rises, the ratio of overhead becomes progressively less significant.

Other disadvantages of group practice are: restriction of freedom of action in respect to vacations, study, travel, attendance on scientific meetings and even publication of medical articles to all members except the heads of the group; comparatively static income of members of a group except that of the owner or owners; salary cuts, then discharge of employees to reduce overhead in times of depression; disruption of groups through death or disability of some able man or men around whom the group has been built, and the difficulty with which physicians are able to find employment in another group or are able to enter private practice when a group closes.

In spite of the extensive data available on the insurance systems of Europe and the evidence which can be produced to show that voluntary health insurance schemes have everywhere failed, the majority of the Committee makes the definite recommendation that this country adopt the thoroughly discredited method of voluntary insurance. A system of voluntary health insurance tied to the visionary medical center plan, which is offered as the "keystone" of all medical service, would plunge the medical profession into similar or more difficult problems than have been experienced by the European professions in its struggle against the various European insurance schemes. In the United States, contract practice is essentially health insurance and has already given rise to destructive competition among professional groups, inferior medical service, loss of personal relationship of patient and physician, and demoralization of the profession. It is clear that all such schemes are contrary to sound public policy and that the shortest road to commercialism of the practice of medicine is through the supposedly rosy path of insurance.

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The objections to compulsory health insurance are almost as compelling to this minority group as are those to voluntary insurance. Proof of the evils of the compulsory system is at hand in our own experience in this country with the only compulsory system with which we have yet had to deal, workmen's compensation insurance. Under workmen's compensation, groups are soliciting contracts, often through paid lay promoters; laymen are organizing clinics and hiring doctors to do the work; standards of practice are being lowered; able physicians outside the groups are being pushed to the wall; the patient is forced by his employer to go to a certain clinic, and the physician is largely under the control of the insurance companies. These are not visionary fears of what may happen but a true picture of widespread evils attending insurance practice. No better example should be needed of what must happen to medical care if compulsory insurance is extended to families.

The total cost of medical care is usually increased when it is paid for through insurance, because the cost of operation of the insurance plan must be added to the cost of medical care and the number of persons sick and the number of days' sickness per capita always increase under any insurance system. The Majority Report registers approval of insurance but disapproves of insurance companies. The minority group agrees with the principle that, in any contract practice plan involving an insurance principle, this principle should be applied through a nonprofit organization. The minority group has not attempted to marshal all the facts or arguments that can be used against health insurance but has endeavored to show that there are great dangers and evils in insurance practice which must be set over against the advantages of distributing the costs of medical care by this method. The minority group believes that the majority report has minimized these dangers and evils.

MINORITY RECOMMENDATIONS

The minority recommendations follow:

"I. The minority recommends that government competition in the practice of medicine be discontinued and that its activities be restricted *(a)* to the care of the indigent and of those patients with diseases which can be cared for only in governmental institutions; *(b)* to the promotion of public health; *(c)* to the support of the medical departments of the Army and Navy, Coast and Geodetic Survey, and other government services which cannot because of their nature or location be served by the general medical profession; and *(d)* to the care of veterans suffering from bona fide service-connected disabilities and diseases, except in the case of tuberculosis and nervous and mental diseases.

"II. The minority recommends that government care of the indigent be expanded with the ultimate object of relieving the medical profession of this burden.

"III. The minority joins with the Committee in recommending that the study, evaluation and coordination of medical service be considered important functions for every state and local community, that agencies be formed to exercise these functions, and that the coordination of rural with urban services receive special attention.

"IV. The minority recommends that united attempts be made to restore the general practitioner to the central place in medical practice.

"V. The minority recommends that the corporate practice of medicine, financed through intermediary agencies, be vigorously and persistently opposed as being economically wasteful, inimical to a continued and sustained high quality of medical care, or unfair exploitation of the medical profession.

"VI. The minority recommends that methods be given careful trial which can rightly be fitted into our present institutions and agencies without interfering with the fundamentals of medical practice.

"VII. The minority recommends the development by state or county medical societies of plans for medical care."

DISTRIBUTION OF MEDICAL COSTS

This minority group agrees that any plan for the distribution of medical costs must have the following safeguards:

1. It must be under the control of the medical profession. (A "Grievance Board" to settle disputes, having lay representation, is permissible and desirable.)
2. It must guarantee not only nominal but actual free choice of physician.
3. It must include all, or a large majority of, the members of the county medical society.
4. The funds must be administered on a nonprofit basis.
5. It should provide for direct payment by the patient of a certain minimum amount, the common fund providing only that portion beyond the patient's means.
6. It should make adequate provision for community care of the indigent.
7. It must be entirely separate from any plan providing for cash benefits.

The minority group states its reasons for favoring thorough trial of the county society plan for furnishing complete medical care as follows:

1. It places responsibility for the medical care of the entire community on the organized physicians of the community.
2. It places medical care under the control of the organized profession instead of in the hands of lay corporations, insurance companies, and so on.
3. It places responsibility for the quality of service directly on the organized profession. It is in fact the only plan that guarantees quality of service and makes it the only basis of competition.

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12. Cash benefits do not form a part of the plan.

SECOND MINORITY REPORT

The second minority report, which was signed by Herbert E. Phillips, D. D. S., and C. E. Rudolph, D. D. S., is in agreement with the first minority report in strongly emphasizing the necessity of maintaining professional standards and the position of the general practitioner. This group agrees with the first minority group that the majority is unduly critical of the professions. The second minority group joins with the first in declaring the medical center plan of the majority a utopian concept involving many problems too visionary or problematic to justify inclusion in an authoritative report of this kind.

The second minority group believe that the method of payment for medical service need not interfere with the highest professional standard or the close personal relations between practitioner and patient. Furthermore, this group is of the opinion that the introduction of compulsory health insurance under professional control would eliminte the objectionable features. It is in accord with the first minority group on the development by state or county medical society of plans for medical care.

The statements of Edgar Sydenstricker and Walton H. Hamilton are largely criticisms of the methods used by the Committee. They are of the opinion that the preliminary studies and the recommendation do not deal adequately with the fundamental economic questions which the Committee was formed primarily to study and consider.

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The Wisconsin Medical Journal

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A Monthly Journal of Medicine and Surgery

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Volume XXXI
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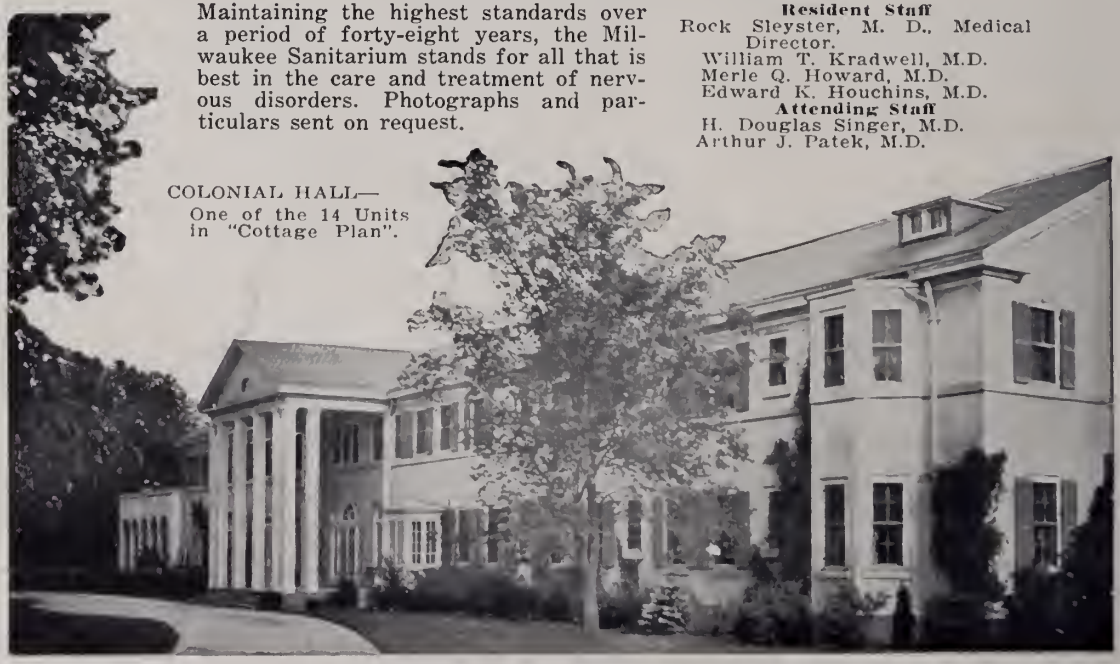

SUPPLEMENT TO THE WISCONSIN MEDICAL JOURNAL
Vol. XXXI, No. 12 : : : : : : : : : : : : : : : : : : : December, 1932

PROCEEDINGS

House of Delegates, Ninety-First Anniversary Meeting, State Medical Society of Wisconsin, 1932

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Fellowship in The American Medical Association . . .

BECAUSE Fellowship is a prerequisite to attendance at the sessions of the American Medical Association to be held at Milwaukee in June, the following statement has been prepared indicating how our members may become Fellows.

All members in good standing in the State Medical Society of Wisconsin are eligible to become Fellows of the American Medical Association. It is required, however, that they make formal application for that relation, pay Fellowship dues and subscribe to the JOURNAL of the American Medical Association. It is to be noted, however, that Fellowship dues and the subscription to the JOURNAL are included in one annual payment of $7. This, with application for Fellowship, is to be made direct to the American Medical Association, 535 North Dearborn Street, Chicago.

Any one of the special journals published by the A. M. A. may be substituted for THE JOURNAL. In case the subscription price of the special journal selected is higher than the subscription price of THE JOURNAL, it is required that the regular subscription rate of the journal selected shall be paid (which will include Fellowship dues). If the subscription price of the special journal selected is less than that of THE JOURNAL, the regular price of $7 must be paid if Fellowship is to be included.

Fellows of the American Medical Association are given a special Fellowship card, presentation of which will admit them to all sessions of the Association at Milwaukee next June.

Be a Fellow.

Proceedings, House of Delegates, State Medical Society of Wisconsin, Milwaukee, September 13, 14, 15, 1932

TUESDAY EVENING SESSION

September 13, 1932

The first session of the House of Delegates of the Ninety-First Anniversary meeting of the State Medical Society of Wisconsin was called to order at seven-twenty P. M., by Stanley J. Seeger, Milwaukee, Speaker.

Speaker Seeger: You will please come to order. In welcoming you to Milwaukee and to this session of the House of Delegates, I wish to impress upon you that you are here as the representatives of your county medical societies. It is not only your privilege, but your duty to see that the important opinions upon matters which are pending are expressed to this House.

On the other hand, the amount of time which we have at our disposal is limited, and the amount of business which we have to transact is rather voluminous, so that I would request you adhere to the matters before us for consideration.

The first order of business is the appointment of Reference Committees of the House, as provided for by the Constitution of the Society. I have appointed the following committees:

Credentials:
H. J. Gramling, Milwaukee, Chairman
I. E. Schiek, Rhinelander
L. V. Littig, Madison

Reports of Officers:
T. J. O'Leary, Superior, Chairman
Edith McCann, Milwaukee
A. J. Gates, Tigerton

Reports of Standing Committees:
Gunnar Gundersen, La Crosse, Chairman
C. F. Peterson, Independence
A. E. McMahon, Glenwood City

Resolutions:
Ralph M. Carter, Green Bay, Chairman
R. G. Arveson, Frederic
R. W. Jones, Wausau
D. E. W. Wenstrand, Milwaukee
G. F. Adams, Kenosha

Speaker Seeger: We will now hear the report of the Committee on Credentials, of which Dr. Gramling is the chairman.

Delegate Gramling (Chairman, Committee on Credentials): Mr. Speaker: Your Committee on Credentials is pleased to report at this time the registration of fifty (50) members of the House, including six (6) Councilors.

No questions have been raised relative to the seating of Delegates or Alternates.

Slips for recording attendance have been passed out and I move that the attendance record so compiled constitute the roll of this session.

Speaker Seeger: Gentlemen, you have heard the motion. Is there a second?

. . . The motion was seconded by Delegate J. F. Mauermann of Monroe, and carried . . .

Speaker Seeger: The Speaker will now entertain a motion to approve the minutes of the 1931 meeting of this House, as printed in THE WISCONSIN MEDICAL JOURNAL.

Delegate L. V. Littig (Madison): I so move.

. . . The motion was seconded by Delegate J. F. Mauermann of Monroe . . .

Speaker Seeger: Is there any discussion? Are there any alterations or corrections?

. . . There was no discussion and the motion was carried . . .

VOTING POWER OF COUNCILORS

Speaker Seeger: Under Unfinished Business:—A year ago, Dr. Spencer D. Beebe of Sparta, presented an amendment to the Constitution which, if adopted, would have the effect of making Councilors ex officio members of the House of Delegates, with the privilege of the floor, but without the right of vote which they now hold.

This amendment has laid on the table for one year, has been twice published in the WISCONSIN MEDICAL JOURNAL, and pursuant to the Constitution, is now before you for your action. The Secretary will please read the amendment.

Secretary Crownhart: Article V of the Constitution now reads:

> "(House of Delegates)
> "The House of Delegates shall be the legislative body of the Society, and shall consist (1) of delegates elected by the component county societies, and (2) the officers of the Society enumerated in Section 1 of Article IX of this constitution."

It provides that the House of Delegates shall be the legislative body of the Society and shall consist of one delegate selected by the component societies; the officers of the Society, which includes the Councilors and the Past Presidents, who shall be ex officio members of the House, but without the right to vote.

Under Dr. Beebe's amendment, the Article would be amended to read:

> "The House of Delegates shall be the legislative body of this Society and shall consist of delegates elected by the component county medical societies; the officers of the Society enumerated in Section 1 of Article IX, of this constitution, and Past Presidents of the Society shall be ex officio members of the House, but without the right to vote."

Attendance House of Delegates, Milwaukee, 1932

Society	*Delegate*	*1*	*2*	*3*
Ashland–B–I	J. W. Prentice, Ashland	x	x	x
	J. M. Dodd, Ashland*	x	a	a
Barron–W–S–B	J. H. Wallis, Rice Lake	a	a	a
	S. O. Lund, Cumberland*	x	x	a
Brown–Kewaunee	R. M. Carter, Green Bay	x	x	a
	W. M. Wochos, Kewaunee*	x	x	a
Calumet	J. W. Goggins, Chilton	x	x	a
	F. P. Knauf, Kiel*	x	a	x
Chippewa	W. C. Henske, Chippewa Falls	a	a	a
Clark	H. H. Christofferson, Colby	x	x	x
Columbia	A. J. Batty, Portage	x	a	a
	H. F. Fredrick, Westfield*	x	a	a
Crawford	C. A. Armstrong, Prairie du Chien	x	x	x
Dane	F. F. Bowman, Madison	x	x	x
	L. V. Littig, Madison	x	x	x
	L. W. Peterson, Sun Prairie	x	x	x
	James Dean, Madison*	a	x	a
	A. R. Tormey, Madison*	a	x	a
Dodge	E. P. Webb, Beaver Dam	a	a	a
	A. W. Hammond, Beaver Dam*	x	a	a
Door	J. Hirschboeck, Forestville	a	a	a
Douglas	T. J. O'Leary, Superior	x	x	x
Eau Claire & Associated	F. C. Kinsman, Eau Claire	a	a	a
	F. E. Butler, Menomonie*	x	x	x
Fond du Lac	D. J. Twohig, Fond du Lac	x	x	x
Grant	E. H. Spiegelberg, Boscobel[1]	a	a	a
	M. B. Glasier, Bloomington*	x	x	x
Green	J. F. Mauermann, Monroe	x	x	x
Green Lake–W–A	A. J. Wiesender, Berlin	a	x	x
Iowa	M. T. Erickson, Highland	a	a	a
Jefferson	H. P. Bowen, Watertown	x	a	a
	W. S. Waite, Watertown*	x	a	a
Juneau	C. C. Vogel, Elroy	x	x	x
Kenosha	G. F. Adams, Kenosha	x	x	x
La Crosse	Gunnar Gundersen, La Crosse	x	x	x
	R. E. Flynn, La Crosse*	x	a	a
Lafayette	R. B. Quinn, Darlington	a	a	a
Langlade	J. C. Wright, Antigo	x	a	a
Lincoln	E. O. Ravn, Merrill	a	a	a
Manitowoc	R. W. Hammond, Manitowoc	x	x	a
	W. A. Rauch, Valders*	x	x	a
Marathon	R. W. Jones, Wausau	x	x	x
Marinette–Florence	G. R. Duer, Marinette	x	x	a
	J. V. May, Marinette*	a	a	x
Milwaukee	J. O. Dieterle, Milwaukee	x	x	x
	Oscar Lotz, Milwaukee*	x	x	a
	E. W. Miller, Milwaukee	x	x	a
	F. D. Murphy, Milwaukee*	a	x	a
	S. J. Seeger, Milwaukee	x	x	x
	H. G. Schumm, Milwaukee*	x	x	a
	H. J. Gramling, Milwaukee	x	x	x
	H. W. Powers, Milwaukee	a	a	a
	R. E. Fitzgerald, Milwaukee*	a	x	a
	C. J. Coffey, Milwaukee	x	x	a
	A. A. Pleyte, Milwaukee	a	x	x
	M. Tufts, Milwaukee*	x	x	x
	S. G. Higgins, Milwaukee	x	x	x
	N. E. McBeath, Milwaukee*	x	x	a
	M. G. Peterman, Milwaukee	x	x	a
	L. W. Hipke, Milwaukee*	x	x	a
	B. Krueger, Cudahy*	x	x	x
	Wm. M. Jermain, Milwaukee*	x	x	a
	F. A. Thompson, Milwaukee	x	x	x
	S. H. Lippitt, Milwaukee*	x	x	x
	D. E. W. Wenstrand, Milwaukee	x	x	x
	R. A. Toepfer, Milwaukee*	x	x	a
	Edith McCann, Milwaukee	x	x	x
	G. W. Neilson, Milwaukee*[2]	a	a	a
	A. R. Bell, Tomah	x	x	a
Monroe	W. R. Berg, Gillett	x	x	x
Oconto	I. E. Schick, Rhinelander	x	a	x
Oneida–F–V	C. D. Boyd, Kaukauna	x	x	a
Outagamie	C. D. Neidhold, Appleton*	x	x	x
Pierce–St. Croix	A. E. McMahon, Glenwood City	x	x	x

Society	*Delegate*	*1*	*2*	*3*
Polk	R. G. Arveson, Frederic	x	x	a
Portage	E. P. Crosby, Stevens Point	a	a	a
	E. E. Kidder, Stevens Point*	x	x	a
Price–Taylor	G. E. MacKinnon, Prentice	a	a	a
Racine	H. B. Keland, Racine	x	x	x
	T. C. Hemmingsen, Racine*	x	x	a
Richland	George Parke, Viola	x	x	x
Rock	W. J. Allen, Beloit	x	x	a
	P. A. Fox, Beloit*	x	x	a
Sauk	H. J. Irwin, Baraboo	a	a	a
Shawano	A. J. Gates, Tigerton	x	x	x
Sheboygan	R. C. Meyer, Plymouth	x	a	a
Trempealeau–J–B	C. F. Peterson, Independence	x	x	x
	H. A. Jegi, Galesville*	a	x	x
Vernon	R. H. Ludden, Viroqua	a	x	a
Walworth	R. C. Halsey, Lake Geneva	a	a	a
Washington–Ozaukee	H. M. Lynch, West Bend	x	x	a
	N. E. Hausmann, Kewaskum*	x	a	a
Waukesha	H. T. Barnes, Delafield	x	x	x
Waupaca	J. W. Monsted, Jr., New London	x	a	a
Winnebago	J. W. Lockhart, Oshkosh	a	a	a
	R. B. Rogers, Neenah*	x	x	x
Wood	F. X. Pomainville, Wisconsin Rapids	x	x	x
	K. H. Doege, Marshfield*	a	x	a

District	*Councilor*	*1*	*2*	*3*
First	A. W. Rogers, Oconomowoc	x	x	a
Second	F. W. Pope, Racine	x	a	a
Third	C. A. Harper, Madison	x	x	x
Fourth	W. Cunningham, Platteville	a	x	a
Fifth	A. H. Heidner, West Bend	x	x	a
Sixth	S. E. Gavin, Fond du Lac	x	x	a
Seventh	S. D. Beebe, Sparta	x	x	x
Eighth	T. J. Redelings, Marinette	x	x	a
Ninth	Joseph F. Smith, Wausau	x	x	x
Tenth	H. M. Stang, Eau Claire	x	x	x
Eleventh	F. G. Johnson, Iron River	x	x	x
Twelfth	R. W. Blumenthal, Milwaukee	x	x	a

x—Present.
a—Absent.
* Alternate.
(1) Illness of wife.
(2) Ill.

Speaker Seeger: Gentlemen, this amendment is now officially before you. According to the Constitution it will be necessary, in order to make this a part of our Constitution, to pass it by a two-thirds vote. Is there any discussion before you vote on this question? Is Dr. Beebe here? Does he wish to say anything more?

Councilor Spencer D. Beebe (Sparta): Mr. Speaker: I did not suppose I would be called upon to speak for or against this resolution. I have asked a good many people who have been members of this House of Delegates, and I have asked a good many Councilors also, if they knew of any particularly good reason why Councilors should have a vote in the House of Delegates.

When I introduced that resolution last year I did it without any animus towards any one of my brothers on the Council, of course. After all, the House should do its own voting, and not be assisted by what would be represented in our national government by the Senate. That is all the argument I have. I just cannot see why the men and women who are entrusted to represent our constituent component societies as delegates, should not do so; I do not know of any good reason why any others should be asked or allowed to vote in the House of Delegates.

You delegates are not asked to vote in the Council,—at least I have never known you to come up and ask for a vote, and I do not know of any good reason why we should come into your House and vote.

I am quite sure I am right, because last year when we brought up this matter Dr. Rock Sleyster agreed with me, and I do not think there is another man in the State Society who knows more about the history of our organization, or has its welfare more at heart. Therefore, I feel it is a resolution worth considering. I thank you for this time.

THIRTEENTH COUNCILOR DISTRICT

Speaker Seeger: Is there a further discussion of this question? (None) If not, I will put the question. Those in favor of the amendment, as read, will please signify by saying "aye"; opposed (none). The motion is carried.

A second amendment to the Constitution was proposed by Councilor F. G. Johnson of Iron River,

to effect a change in the composition of the Eleventh Councilor District. I will ask the secretary to read this amendment.

Secretary Crownhart: Mr. Speaker:

"WHEREAS, Notice was given at the 90th anniversary meeting of the State Medical Society of Wisconsin that an amendment to the Constitution be proposed dividing the present Eleventh District and creating a new district to be known as the Thirteenth Councilor District, and

"WHEREAS, After four years of discussion, it is the sense of the membership in the present Eleventh District that the distance from one end of the district to the other (over 300 miles) is too large to permit of the cohesive district society, and

"WHEREAS, It is the expressed desire of the membership that the district be divided so that the Eleventh District shall, in the future, consist of Douglas and the Ashland-Bayfield-Iron county medical societies with a membership of sixty-eight (68) and that a Thirteenth Councilor District be created to consist of Oneida-Forest-Vilas, Langlade and Price-Taylor county medical societies with a membership of fifty-five (55); therefore, be it

"*Resolved*, That the House of Delegates of the State Medical Society of Wisconsin at its 91st anniversary meeting, hereby approves the creation of the new district and the division as indicated.

"*Further*, That the House approves the following amendment to the Constitution which is necessitated by this change: Article 9, Section 2, amend the Constitution by inserting a period instead of the semi-colon following the words 'three years' where it appears in the second sentence. Further amending the section by striking out the rest of the section and substituting therefore the following: '*As nearly as possible, one-third of the members of the Council shall be elected by the Council. All these officers shall serve until their officers are elected and installed.*'"

The purpose of the constitutional amendment is simply to provide for a thirteenth councilor district, and where the present Constitution says one-third of the Councilors shall be elected each year, that is changed to read "as nearly as possible", because we cannot elect, if we have thirteen councilor districts, a precise one-third.

Speaker Seeger: Mr. Crownhart, do I understand this has been published?

Secretary Crownhart: The announcement has been made in the JOURNAL.

Speaker Seeger: Is there any discussion of this proposed amendment? Is Dr. Johnson here?

Dr. F. G. Johnson (Councilor, Eleventh District): Mr. Speaker, and Members of the House: I have no doubt but that this district in an early day was mapped out on the basis of railroad travel, but in recent years travel is all by automobile and at the present time it is absolutely impossible for the members of the eastern part of the district to attend our meetings in the western part, and vice versa—those in the western cannot attend the meetings in the eastern part without spending at least two days.

There is perfect unanimity about the division of the district, and so far as the district itself is concerned there has been no objection.

There may be a further alignment made. In another year perhaps we may ask an addition, or perhaps the counties to the south of us will like to join the Ashland–Bayfield–Iron–Douglas County district. But that will be attended to at a later time.

Speaker Seeger: Is there any further discussion of this proposed amendment? Is it clear to all of the membership? (No dissent) I will ask you to vote on the question as was stated by the Secretary, relative to the amendment of the Constitution of this Society. Those in favor will signify by saying "aye"; opposed (one nay vote recorded). The motion is carried.

The next order of business is the report of Officers and Committees. These reports having been printed in the August issue of THE WISCONSIN MEDICAL JOURNAL I will call upon the officers and chairmen to summarize important points and to make such additions as they desire.

The first is the report of the Chairman of the Council, Dr. Rogers.

Dr. Arthur W. Rogers (Chairman of the Council): Mr. Speaker: As you stated, the report has been printed in the JOURNAL, and I trust has been properly read. I move its adoption.

Speaker Seeger: The report of the Chairman of the Council is automatically referred to one of the reference committees of the House. It will be adopted at a later time.

The next is the report of the Secretary of the Society, Mr. Crownhart.

REPORT OF SECRETARY

Secretary Crownhart: Mr. Speaker and Members: The membership report of the Society, as published in the August issue of the JOURNAL, was as of July first.

I now have for you the report as of last Saturday. At the end of the last calendar year we had 2,120 members. At the present time we have 1900 members who have paid, seventeen who have made partial payment, and thirty-three applications for membership which we understand have been passed. We thus have to date a total membership of 1927, a loss of 145 over last year.

It would appear, Mr. Speaker, that our membership will very nearly approach that of a year ago, and be comparable to that in the surrounding state societies.

As Secretary of your Society your Secretary also acts in that capacity for each of the Society's committees. The work is always comprehensive, but during the past year, the many studies for the Special Committee on Distribution of Medical Services in Wisconsin have demanded the utmost in time. That you might have a better understanding of what took place in making these studies, I have with me tonight, so that you can see it, the master book for one study which included 30,000 entries, and yet, when published, constituted in summarized form but two pages of the 35-page printed report.

In the field of scientific work, we are very happy to report that we have been able to secure from the Emergency Board of the State a $500 appropriation, which, with the cooperation offered by the University, has been sufficient to assure continuance of the Medical Library Service. In this connection, it is of interest to note that, while a similar service of the American Medical Association serving the members throughout the country, filled, in the last calendar year, 2,450 requests, the Medical Library Service in our own state for our own members, in the same length of time, filled 4,425 individual requests. The Medical School, I am sure, deserves our very hearty commendation for its willingness to assume the very considerable effort and financial burden that was put upon them in carrying forward this work when the legislature failed to make the necessary appropriation.

Monthly bulletins to the officers have continued to bring to their attention program material, particularly speakers from within the state from our own membership that are available for their monthly programs.

Your Secretary takes this opportunity to express his personal appreciation to Dean McGrath of Marquette University School of Medicine, for his cooperative efforts which culminated in being able to furnish the county officers with a list of selected subjects and selected speakers from the faculty of Marquette University, likewise available for county society meetings.

Your central office has endeavored to be of every possible assistance to the Extension Department of the University, in carrying forward the successful post-graduate courses that have been held each summer. During the last summer we had two such courses and during the year three courses were given in Madison.

While the JOURNAL has been self-supporting over a period of five years, the presently decreased advertising, together with the high standards of the JOURNAL in the advertising department, which we must maintain, has made necessary calling upon the Society for financial aid. It has not been possible, currently, to maintain our record of a self-sustained JOURNAL.

It is to be noted that the JOURNAL has not decreased the size of its scientific section, and that in the back part of the JOURNAL we have continued to carry those articles which we felt were of informative value in advising physicians on the various fields that relate to the practice of medicine.

It will be of interest to you to know that even though we have had to call, or will call, upon the Society's general fund during the current year for some $1500, this is but a third of what it cost the membership to maintain a similar JOURNAL in an adjoining state, and, so far as we know, no State Society is furnishing a similar JOURNAL to its members at a lesser cost.

We have continued to open the exchange advertising columns of the JOURNAL to members without charge.

A special session of the legislature was held during the winter months of this present year, and the one measure that physicians were particularly interested in was that proposal which would institute an eight-hour day in industry which would not, in its basic requirements, exempt hospitals.

We were able to point out after detailed studies that required a complete survey of a hospital situation in Wisconsin that, if we included hospitals in an eight-hour day bill, the added cost would be in excess of $600,000 a year.

We were able to point out that hospitals had in their investment some $26,000,000 upon which they still owed $14,000,000; that if this added burden was placed upon the hospital at a time when its charity source was largely decreased, and in some instances cut off, it would simply mean a new burden that would have to be passed along to the patient at a time when he was less able to pay the costs of his illness.

I think it is self evident to physicians that had the patients of Wisconsin been forced to pay any such additional sum of $600,000 a year to the hospitals, in part this burden would have been passed on to the physician's shoulders. We were able to secure from the Interim Committee of the legislature, which prepared this legislation, an exemption for hospitals as their original report.

It was the only exemption in the entire measure, and while the bill did not finally pass the legislature, we appreciate that it will be back until it does pass, and the fact that hospitals were exempted in the first instance indicates they will probably be exempted whenever the measure is passed by the legislature.

Of foremost importance in the field of our legal services, was the compilation of a 16-page leaflet on Poor Relief Laws Affecting Care of the Indigent Sick.

Our original publication was in the number of 1800, and you will be interested to know that our files have so many letters from Poor Relief officers requesting this publication that we have had to run 4,000 additional copies, and are now faced with having to run a fourth edition.

The leaflet was sent to every member outside of Milwaukee County where their own set-up made this particular compilation of state laws ineffective. For the first time in the history of the Attorney Gen-

eral's Department, the Attorney General of the State approved this unofficial compilation of the laws and our statement of the legal responsibility of Poor Relief officers towards providing medical service for the indigent.

In the field of legal information generally a countless number of requests have been made during the year for opinions relating to such questions as the responsibility for poor relief, who may be entitled to use the title "Doctor", fees of an assistant surgeon, the liability of a third party for costs of medical service, the statute of limitations with respect to malpractice action brought by a minor, the liability for the illegal acts of a nurse in industry, the liability for overdosage, fees for expert testimony, practices under Workmen's Compensation Act, the expulsion of a member, and many relating to the corporate practice of medicine and like subjects.

The files on these opinions in the past years, and those that we are adding from year to year, have become exceedingly useful in answering promptly requests that are made upon us by the county medical societies as well as the general membership.

Under this title may also be mentioned the studies made through this office with respect to collection agencies and their contracts. It may interest you to know hardly a week goes by that we do not advise some secretary of a medical society of the fraudulent nature of, or illegal practices of a collection agency soliciting Wisconsin physicians.

Warnings have also been issued to the general membership and constituent societies on the questionable practice of some insurance carriers who have been endeavoring to secure agreements from members to reduce fees for compensation cases by misleading statements that other physicians in other counties were making such reductions.

In the field of income tax deductions, we have again published those deductions and depreciations peculiar to the practice of medicine which are permitted by the state and by the federal government. Two items were added in 1932 to the state decisions relative to the deductibility of expenses for attendance at medical conventions and subscriptions to medical journals. These represent, in the estimation of the Wisconsin Tax Commission very large and entirely legitimate savings to the membership as a whole.

In the field of Radio and Press education, during the past ten months we have prepared 105 radio talks which have been broadcast over the University station, partly in hook-up with other stations. In addition we have forwarded these talks to Stevens Point and to Sheboygan where representatives of the county medical societies in those two cities are using our material for local broadcasts.

On a voluntarily reduced budget the Press Service of your Society has been continued during the present year, and I believe this effort has done more than possibly any other single endeavor to bring to hundreds of thousands of readers information, accurate as to detail, relating to the causes, means of relief, and prevention of disease, and particularly the services that the family physician stands ready to render to the public.

By permission of the Council your Secretary is now in his second year as the elected Secretary of the Wisconsin Hospital Association, serving without compensation. The purpose of this affiliation, as you will appreciate, is to join the common interests of the two societies and to make possible accomplishments that would not be possible without such a joining of interests. The value of this association was evidenced during the year by our appearance in that joint capacity on the eight-hour-day bill, the survey on the care of veterans, other surveys on hospital practices, the amount of room available and those of like nature.

In the field of alleged illegal practice by nurses in industry, eighteen months ago your Council authorized a special committee to study this subject matter. The Committee has completed its work and has issued to every nurse in industry in the state of Wisconsin, with the approval of the Council, a special pamphlet outlining the work that a nurse may well undertake, and indicating specifically that which she should not undertake because of the limitations of her education. Upon our recommendation some three weeks after this pamphlet was issued, following a case where a nurse grossly violated the terms as set forth, the State Health Officer cooperated with the Society and a letter was sent to each nurse in industry in the state of Wisconsin. This letter called attention to the publication of this leaflet, to the violation by this one nurse, with the identification omitted, and calling attention to the fact that it was most essential this very careful study be followed in every detail.

I think, on the whole, the nurses in industry have shown a very cooperative spirit, and notably in rendering splendid assistance in many of our legislative activities.

For several years your Secretary has pursued the policy of addressing a personal letter to each licentiate as he enters the profession in Wisconsin. In this letter we expressed our desire to have him as a guest at the coming meeting of the constituent Society in whose jurisdiction he would reside. We have offered our services as they might be helpful in suggesting locations to him for practice in this state.

During the current year this Placement Service of your Society has been of very great importance. We have been in position to advise against locations as well as to suggest them. We think this is very important, because we find many, many instances where men plan to go into some small community and we know from our studies, which have just been completed, those who are there are just barely eking out a living. The addition of one more would make it all the more impossible for all of them successfully to pursue their practice in that locality.

As a service to estates of physicians, we address

personal letters to the widows as soon as possible calling attention to the fact we desire to be of every service. We offer the advertising columns of the JOURNAL and warn against the unscrupulous methods employed by some collecting agencies in trying to collect, and have the widow sign over to them, the accounts of deceased physicians.

Your Secretary is particularly pleased to announce the American Medical Association has accepted the joint invitation of your Society and that of the Medical Society of Milwaukee County to hold its next meeting in Milwaukee, in June, 1933. Pursuant to your action a year ago, when the A. M. A. convention meets in Milwaukee, we, of Wisconsin, will confine our meeting to a meeting of the House of Delegates.

A study of model constitution and by-laws for the component societies is now under way, and a revised copy will be issued before the year is over.

The work of your State office during the current year would have been impossible without the able and efficient service of the three assistants who you employ in that office. This small staff cannot very well be decreased if we are expected to maintain the work for the coming year.

The current year has necessitated the Secretary remaining at Madison as much as possible because of the Special Session of the Legislature, and by reason of over thirty meetings of the Council and committees.

And in this connection, Mr. Speaker, I would like to say to the members of the House that I think few appreciate the tremendous amount of time and effort given to this Society by the members of its committees and its Councilors. A committee meeting that may be a matter of half an hour, or forty-five minutes, or an hour and a half, within the boundaries of a given county or city, is rarely possible when considering the work of the State Society. Frequently members have to give a day in going, a day at headquarters, and a day in return, and the fact that we have had thirty such meetings during ten months indicates the tremendous sacrifice by the members of the Committees and Council to carry on the work of the Society.

No one appreciates more than your Secretary that in this period of economic pressure the general membership will welcome extraordinary efforts in their behalf, the result of which will be either to lower their expenses or increase their income, and I think it is proper that the House give this its close attention.

It is self-evident that the period which increases our economic pressure brings to the profession problems of still greater importance and urgency, particularly as may be anticipated in the coming legislative session. Detailed data on just what may be expected in activities at several levels of income has been presented by the Secretary to the reference committee of your House for their recommendations to you, and your subsequent actions as an entire house. Whether the greater economy will be represented in a material reduction in dues or in maintaining the present level to bring continued dividends through fairly anticipated accomplishments, is a question your House must determine.

Your Secretary is deeply conscious of the fact that whatever accomplishments he has been able to report at this meeting (his tenth) has been made possible by the splendid degree of cooperation given by Councilors, committeemen and members throughout this state. Few will ever know of the hours they have given or of the calls they have responded to made by wire, by long distance or by special delivery. Your Secretary is deeply conscious of their devotion, and as President Fiedler recently stated in a recent issue of the MILWAUKEE TIMES, it is one of the crowning glories of the State Society that all we have to do is to issue a call, and we are assured of the response.

Your Secretary is a contact point between the profession and the public, and in no matter what part of the state you may reside, he is still your Secretary. He asks at this time, as at every other previous meeting, your suggestions and your criticisms. (Applause)

Speaker Seeger: The next report is that of the Treasurer, Dr. Rock Sleyster.

REPORT OF TREASURER

Treasurer Sleyster: Mr. Speaker: I think as a Society we can feel very well satisfied with the financial condition that prevails. Compared with our parent organization and the collections of other state societies, I do not think any other state is in as good condition as we are.

This report is as of September 10, 1932, and is as follows:

	General Fund	Med. Defense Fund
Balance January 1, 1932	$ 773.18	$ 1,535.77
Receipts to Sept. 10, 1932	28,667.87	2,340.50
	$29,441.05	$ 3,876.27
Disbursements to Sept. 10, 1932	18,507.67	2,701.15
Bank Bal. in Funds September 10, 1932	$10,933.38	$ 1,175.12

RECAPITULATION OF FUNDS

General Fund:		
Bank Balance Sept. 10, 1932	$10,933.38	
Investment Securities	25,000.00	$35,933.38
Medical Defense Fund:		
Bank Balance Sept. 10, 1932	$ 1,175.12	
Investment Securities	9,000.00	10,175.12
		$46,108.50

INVESTMENT SECURITIES

General Fund:			
Northern States Power Co.	1941	5%	$ 4,000.00
American Tel. & Tel. Co.	1936	4%	4,000.00
Wisconsin Public Service Co.	1942	5%	3,000.00
T. M. E. R. & L. Co.	1961	5%	2,000.00
Milwaukee Gas Light Co.	1967	4½%	2,000.00
Canadian Nat'l Ry. Co.	1969	5%	2,000.00
City of Milwaukee	1936–37	4½%	3,000.00
Ironwood & Bessemer Ry. & Lt. Co.	1936	5%	1,000.00
Beloit Water, Gas & Elec. Co.	1937	5%	1,000.00

Wis. Power, Light & Heat Co.	1946	5%	1,000.00	
St. Joseph's Congregation, Racine	1941	5%	1,000.00	
N. Y. State Elec. & Gas Corp.	1980	4½%	1,000.00	
				$25,000.00
Medical Defense Fund:				
Commonwealth Edison Co.	1957	4½%	$ 2,000.00	
Bell Telephone Co. of Canada	1955	5%	2,000.00	
Pacific Tel. & Tel. Co.	1937	5%	1,000.00	
North American Co.	1961	5%	2,000.00	
Wisconsin Gas & Elec. Co.	1952	5%	1,000.00	
Milwaukee County Sewer	1944	4½%	1,000.00	9,000.00
Total Bonds				$34,000.00

Analysis Medical Defense Fund:		
Bank Balance January 1, 1932	$ 1,535.77	
Receipts, dues	1,978.00	
Receipts, interest on Bonds	362.50	3,876.27
Paid to attorneys	$ 682.90	
Bonds purchased	2,018.25	2,701.15
Bank Bal. Medical Defense Fund Sept. 10, 1932		$ 1,175.12

(Applause)

Speaker Seeger: The next is the report of the Committee on Necrology, of which Mr. Crownhart is the Secretary.

Secretary Crownhart: Since the publication of the report of the Committee on Necrology in the August issue of the JOURNAL, we have the report of the death of one additional member:

R. C. Blankinship, Madison,

and the death of the following physicians who were not members:

H. B. Johnson, Tomah,
Clara L. Normington, Janesville,
Adolf Pannkoke, Milwaukee.

Speaker Seeger: This report will be adopted at this time by rising vote, and the House will remain standing for a moment in memory of those who have died during the past year.

. . . The House of Delegates rose and stood in a tribute of silence . . .

Speaker Seeger: Next is the report of the Committee on Public Policy, Dr. Otho A. Fiedler, Chairman.

President Fiedler: Mr. Speaker: We have no further report to make than that which appeared in the JOURNAL, except that we come to the House of Delegates to ask for instructions as to what shall be done in regard to the legislation that was introduced last year relative to the composition of the State Board of Medical Examiners. At the last session we met with considerable opposition. We understand that the opposition of the group that opposed us last year is to be removed, and it is very probable that in the coming session we can secure legislation we desire; namely, that the Board shall be composed of seven practicing physicians, with no regard to particular school of medicine from which they happen to graduate. Lacking instructions from the House on this matter we shall assume that we are to re-introduce this measure at the next legislative session.

Speaker Seeger: Next is the report of the Committee on Health and Public Instruction, Dr. Stovall of Madison, Chairman.

Secretary Crownhart: Mr. Speaker, Dr. Stovall is unavoidably detained in Madison by reason of representatives of the American Society for the Control of Cancer visiting Madison to discuss with him the Society's future activities on this subject matter. He states he has no addition to make to this report, and asks me to make his apologies for his unavoidable absence.

Speaker Seeger: We will have the report of the Committee on Medical Education and Hospitals, Dr. Bardeen, Chairman. (No report)

The next is the report of the Committee on Medical Defense, Dr. Patek, Chairman.

MEDICAL DEFENSE

Dr. Arthur J. Patek (Chairman, Committee on Medical Defense): Mr. Speaker and Gentlemen: I want to ask your indulgence for a few minutes to amplify somewhat the report that has been published in the JOURNAL. Necessarily that report was a very brief one, but since it was issued, your Committee has met and formulated plans of which I believe you should be acquainted.

Wisconsin was the third state, I think, to adopt the Medical Defense and naturally the subject matter was new to us at that time. We were more or less at sea in the methods we had to pursue and did pursue. The practice of medicine has changed quite a bit since the early days, and there are certain episodes in medical practice that have occurred since then, in which Medical Defense enters very largely, that have made it necessary for us to determine upon a change of policy—at least a change of plan.

The x-ray, as you may all remember, was very little used in the early days, and now that it is in such general use, the use of the x-ray is very wide-spread in application, and all kinds of medical work necessitates this protection that the medical men must seek for themselves.

To go through this matter very briefly, I may say that under an early section of the By-Laws, the Committee on Medical Defense was empowered to make plans and rules for its development of the work under the Medical Defense plan.

Because of the authority that was conferred upon that Committee and having seen fit to change very materially the formulas under which we are working, your Committee has met and has adopted certain rules that will govern its action in the future. I believe they are of sufficient importance to members to make it worth while to tell you what they are, and I shall try to be very brief in so doing.

In the first place, as you know, the Society does not indemnify the members against judgment. Judgment may be paid by other indemnifying agents, but not by the Society. That, of course, has not been changed.

There are certain conditions under which Medical Defense will be refused: In the first place, a

member must not be in arrears to his Society, or State Society. That means he must not be in arrears after March 31st of the particular current year in which he desires defense. Anybody in arrears after that date is not eligible for protection, should a case present itself.

Furthermore, we have adopted a blank which is more elaborate than anything we have hitherto been using, based to some extent on a composite of blanks used in other states. The blank is meant for information of very detailed character. Hitherto we have acted on a rather loose plan, but henceforth we shall have a very detailed report before we issue the instructions to our attorney to come to the particular litigant's defense.

We are to make a point that the Society, having once undertaken defense of an individual, has some authority over that defense. We shall not permit anybody to settle an action without the consent of the Committee on Defense, or without consent of the Committee. We feel that is very essential. Any attorney who undertakes a case will not permit a client to go behind his back and settle a case, and we, therefore, having assumed certain obligations in any defense act feel that the Society has a certain right to determine whether or not a case shall be settled. Of course there is immense latitude to be used in any case of that kind. But in general, that is one of the rules that we shall insist upon.

Where a member is protected by an insurance organization, we, of course, cannot restrict him in any sense at all in the manner in which he cares to pursue his litigation. We will, however, in all cases, as we have in the past, assist anybody by giving counsel, even though another insurance organization has undertaken the defense primarily.

The more important paragraphs pertain to the subject of the refusal to offer medical defense.

In the first place, where the base of the complaints is service performed outside of the state of Wisconsin, we feel we should not be asked to serve. Laws in other states are different than those in our state. We cannot control a member outside. We cannot give attorney's service outside of our state. Local attorneys must hold there, and local laws, and we feel we cannot, or should not, protect anybody for anything that has occurred outside of the state.

Perhaps the most important point we shall insist upon in the future is that a member shall not be defended if he sues for the collection of his fees under the two-year period, after the service has been rendered. You know that after two years have elapsed, a suit for malpractice is outlawed. That is, the statute of limitations outlaws a suit for malpractice after the two years from date of the last service. We feel any physician who sues under a two-year period, unless suit has already been brought against him, should not be protected, because he is simply jeopardizing his own integrity and that of the Society.

We feel it is no more than right, and this is the plan that is pursued in other states,—that unless a man is forced to sue, which he may be by a suit already being brought against him,—if he is then forced to sue for his fees, certainly we can protect him. But he should wait, unless there are certain circumstances that make it desirable for him to want to sue—for at least two years. Then by the statute of limitations he is entirely free, and no counter claim can be brought against him.

We do not wish to protect a claim for any attempt at criminal abortion.

The last paragraph I shall cite is the protection of the case of fractures. We have had so many cases of suit brought in the case of fractures in which x-rays were not used at all, that we feel we should enforce the particular clause making it mandatory upon the individual or physician to take x-rays in every case of fracture, and if he has not done so to fortify himself by reasons for not having done so.

I know all of you feel that a doctor is to be censured severely if in case of fracture he does not take an x-ray, and we have protected him so that if there is a reason for his not having taken it, we certainly shall give him the services of our legal department. But if he fails to do so and invites a bad result, and then a suit upon that, there is no reason why the State Society should hold itself to the onus of protection in that instance.

Suits instituted against the estate of a deceased member will be defended as if the member were alive.

We have also added that members will be defended for claims based upon alleged breach of contract.

Any decisions rendered by the Committee may be appealed to the Council of the Society, whose decision shall be final.

In listening to the report of your Treasurer and Secretary this evening, I again call attention to the fact that we feel too few members have availed themselves of the privilege of having defense at the small rate of two dollars per year.

Only about sixty per cent of the membership of the Society is enrolled in the Medical Defense. And knowing what we have offered in many cases, and how much it has cost in individual cases, we feel that while we do not need the money, we would like to have the support of many more members of the Society in this particular service that we are offering. (Applause)

Speaker Seeger: Our next report is the report of the Editorial Board, Dr. Lotz, Chairman.

EDITORIAL BOARD

Dr. Oscar Lotz (Chairman of the Editorial Board): I have no additional report except to suggest that you will call on Dr. Huston, our Medical Editor, who is with us tonight.

Dr. John Huston (Milwaukee, Medical Editor of the JOURNAL): Mr. Speaker and Members: I believe the members of the Medical Society will have noticed there has been little or no change in the JOURNAL during the past year. I think this is a

tribute to the men who have had the administration of the JOURNAL in the past. It is very easy to be dissatisfied with a thing, but I found that it is more difficult to make a constructive change.

The field in which the JOURNAL has its greatest function, I believe, is in a post-graduate education. The JOURNAL cannot hope to obtain highly scientific research articles which represent a great deal of work. The men have too many other journals and publications in which to publish these articles, and this type of work.

On the other hand, there is a great opportunity for the older men to instruct the younger, and those who have not had the same opportunity for clinical development and experience. I believe that the older men in the profession should feel a responsibility to impart some of their experience and knowledge to those who have been less fortunate.

I think another field in which the JOURNAL has a future is the development of the younger man; the internes, house officers and the residents, all of whom are seeing interesting cases. Only a very small proportion of these cases is ever published. And I believe that our JOURNAL clinic section offers opportunity for a higher calibre of clinical case report.

I believe that the innovation of the Milwaukee County Medical Society in encouraging the younger man to write up some interesting report of a case that he has seen during his hospital interneship offers something very constructive. The calibre of the JOURNAL, I believe, reflects the quality of the medical service in the state, and I believe that in Wisconsin, with two high class medical schools, and an alert profession, the JOURNAL can make successful strides, and I hope that will be the case.

I want to say I have enjoyed the past year as Medical Editor of the JOURNAL, and I express my appreciation for the many acts of consideration by Mr. Crownhart and the Editorial Board, and those members of the medical societies with whom my work has brought me into contact. (Applause)

Speaker Seeger: The next is the report of the delegate to the A. M. A., Dr. W. E. Bannen of La Crosse. See addendum.

Delegate H. J. Gramling (Milwaukee): Mr. Speaker: If I am in order, I just wish to state Dr. Bannen has been very modest. To get the A. M. A. into Milwaukee was much harder work than he has stated. I am here to tell you that. I was down there and saw him work. You would be surprised at all of the obstacles they have to overcome to get the convention here, and therefore the delegates to the A. M. A. really deserve the thanks of this Society for their hard work in getting the convention here for 1933, and I so move.

Speaker Seeger: Gentlemen, you have heard the motion. Is there a second?

. . . The motion was seconded by Delegate J. F. Mauermann of Monroe . . .

Speaker Seeger: Motion has been made and seconded that we express the thanks of this House of Delegates to our Delegates to the A. M. A. for their efforts in securing the meeting for Milwaukee for next year. All those in favor signify by saying "aye"; opposed, the same. The motion is carried.

These reports are now referred to their respective reference committees of the House.

The Committee on Reports of Officers will consider the reports of the Chairman of the Council, the Secretary, and the Treasurer.

The Committee on Reports of Standing Committees will consider all of the other reports, excepting that on the Committee on Necrology, which has already been adopted.

Gentlemen, a few years ago the House of Delegates of the A. M. A. authorized the formation of a Woman's Auxiliary to the A. M. A., of which we have in this state a component society.

This Society has been increasing its activities and its membership, and during the current week is laying plans for the meeting of the A. M. A. which will be held here next year, at which time the National Auxiliary to our Association will also hold its meeting here.

I note in the house Mrs. Walter Jackson Freeman, the President of the National Auxiliary, and I am privileged to invite her to say a few words to us at this time relative to the National Association. I will ask Dr. Sleyster to please escort Mrs. Freeman to the Chair.

. . . Rising applause . . . (Mrs. Freeman read her prepared manuscript. See Auxiliary page 857 this issue.) . . . Rising applause . . .

Speaker Seeger: We have two special committee reports to receive this evening:

One, the Special Committee on Distribution of Medical Services in Wisconsin.

Two, the Special Committee on the Investigation of Admissions to the State of Wisconsin General Hospital.

These reports will be summarized by the chairmen of the respective committees, and then, in accordance with Chapter III of our By-Laws, will be referred to the Committee on Resolutions, which will report to this House tomorrow night.

Usually, discussion on Committee Reports is not held until the report of the Reference Committee, but I believe, because of the general interest which has been manifested in these Committees, and their work, it would be advisable to alter our procedure on this occasion. If any member wishes to discuss these reports, for the information of the Committee on Resolutions, which is to act upon them, he may do so this evening, unless there is some objection to it.

Furthermore, I believe that because of the nature of the material which is to be presented, and in order to facilitate free discussion, it would be advisable for this House to go into executive session, and I will entertain a motion at this time to that effect.

. . . It was moved by Delegate F. A. Thompson of Milwaukee that the House of Delegates go into executive session. The motion was seconded by Delegate L. V. Littig of Madison. There was no

discussion, there were none opposed, and the motion was carried . . .

Speaker Seeger: I will appoint Mr. Theodore Wiprud, Milwaukee, Dr. I. E. Schiek, Rhinelander, and Dr. J. O. Dieterle of Milwaukee as sergeants-at-arms to see that none but members of the State Society and invited guests are present.

The House will please come to order, and we will have the report of the Special Committee on Distribution of Medical Services in Wisconsin, Dr. Gilbert E. Seaman, Milwaukee, Chairman.

MEDICAL SERVICES IN WISCONSIN

Dr. Seaman: Mr. Speaker, Gentlemen of the House of Delegates: As the Speaker indicated, this report will be very brief. Inasmuch as it has been distributed to all members of the House of Delegates, and the Council and Officers of the Society, (see page 941) it is presumed that it has been read by those gentlemen, and I do not think that any purpose would be served by an attempt at a summary of the report. However, the report is well summarized in the brief introduction, which reads as follows:

> "This committee appointed by President Fiedler upon authorization of the 1931 House of Delegates submits the following report of progress. In the reading of this report the following fundamental facts should be kept in mind at all times:
>
> "(1) Working with restricted funds and a small staff, we have endeavored to limit our studies to the obtaining of those facts which would give us a clear cut picture of the Wisconsin situation.
>
> "(2) In the main your Committee has limited its efforts to fact-finding studies. Its conclusions and recommendations represent only thought of the Committee and are not to be interpreted as representing the thoughts of any others or the Society proper until after appropriate action by your House. The factual studies were made for the Committee by the Secretary of the Society, his assistant and office staff.
>
> "(3) These studies are not presented as representative of anything else than our sincere effort. We frankly concede some probable percentage of error in our estimates and can only state that we have used every means that the report might not be biased.
>
> "Your Committee is in accord with the statement of Dr. David Cheever, Boston, when he declared that the profession of medicine and its practitioners 'have no vested rights which are incompatible with public well-being.' This basic truth has motivated every activity of your Committee, believing as we do that only by advancing the public interest may we truly and permanently advance the interests of each individual practitioner of medicine in this state.
>
> We urge that our studies be given your thoughtful consideration to the end that our Society as an organization may of itself suggest that social effor. which will best promote for the future that joint and indivisible interest of the earnest practitioner of medicine and his patient."

In the January number of THE WISCONSIN MEDICAL JOURNAL, the President, Dr. Fiedler, outlined what seemed to be the idea of the Society in connection with this study, and I will say that, as nearly as possible, this Committee followed the outline therein indicated.

One of the subdivisions of the work was the important matter of contract practice, and it seemed to the Committee that inasmuch as the Medical Society of Milwaukee County had already appointed a Special Committee on that subject, and, inasmuch as perhaps the most important work along the line of industrial and contract practice in any one county in the state was to be found in Milwaukee County, it would be well to subsidize, as far as we were able (to pay in part at least), the expense of this investigation in Milwaukee County, and to apply it, in so far as it was applicable, to the consideration of contract and panel practice throughout the state.

It was determined by the Committee, after also having made a study in Rock County, and in Polk County, which is alluded to in the report, that the questions were not so vastly different in the rural county, or in the semi-urban county, than they were in Milwaukee County. So that on page 26 of the report, we call attention to the fact that we welcomed the cordial cooperation of the Medical Society of Milwaukee County, and took part with them in the study of this question, and we submit as part of our report, the report of the Committee on Contract and Panel Practice, made by the Committee on Social Medicine and Medical Economics of The Medical Society of Milwaukee County, of which Committee, our Speaker, Dr. Seeger, is the chairman.

I think I would not be rendering a full report if I did not express appreciation of the cooperation and the work of the officers of the Society, and particularly of the Secretary, and his office force. Needless to say, I think it would have been impossible to have made any such report as has been made, without the work they did, and that they are able to do. As a matter of fact, such credit as may be due on this report is largely due to the Secretary of the Society.

And likewise, the Committee wishes to express its appreciation of the cooperation and assistance accorded the Committee by the Director of the Bureau of Economics of the American Medical Association, Dr. Leland, and also, its appreciation of the aid that was given by the staff of the Committee on the Cost of Medical Care, operating from Washington.

The Committee realizes the fact that this report, if it is to be of value, must be gone into in detail. Doubtless it will be discussed. I think it should be

discussed. It is a report of progress. It does not purport to be a final disposition of the numerous questions discussed, and I do not think that any purpose would be served at this moment by a more lengthy report from the chairman of the Committee. (Applause)

Speaker Seeger: Gentlemen: You have received the report of Dr. Seaman's Committee. Does any member wish to discuss this report for the information of the reference committee of the House to which it will be referred?

Has anyone any questions he wishes to ask Dr. Seaman?

As you understand, this report will be studied by the reference committee of the House, and its recommendations on these reports will be received by you for action tomorrow evening.

Secretary Crownhart: Mr. Speaker, I know I voice the desire of the Committee that anyone that has any comment to make on this report, or on the succeeding one, will not hesitate to do so. They are before you for your approval, and if you have comment that will aid the Resolutions Committee on arriving at a decision that will be helpful to the House, I hope no one will withhold it.

(No discussion)

Speaker Seeger: I rather hesitate to close this important subject, however, without some suggestion to the Committee. It is not closed finally, of course, because it will be up for your consideration tomorrow evening.

Since there seems to be no present discussion, I will call on Dr. Reginald Jackson, the Chairman of the Committee on Admissions to the Wisconsin General Hospital, to make his report.

WISCONSIN GENERAL HOSPITAL

President-Elect Reginald H. Jackson (Chairman, Madison): Mr. Speaker and Members of the House of Delegates: The report of the Special Committee appointed by the Council to investigate all types of admission of patients to the Wisconsin General Hospital, and report to the House of Delegates to this meeting, is in print, and in the hands of the delegates and officers of the component societies. (See page 985).

I am happy in inform you that last Friday, on the invitation of President Frank, your chairman and five members of the Committee, met with the Executive Committee of the Regents of the University of Wisconsin, and the Executive Committee of the Wisconsin State General Hospital.

We were in conference for three hours, and I think we went a long way toward ironing out many of these irritations which are upsetting us, and I am hopeful that in future conferences we may continue without undue publicity, which might harm the profession and the institution.

I will ask, with your permission, that Mr. Crownhart read the letter which our Committee sent to President Frank the day after our conference. (Applause)

Secretary Crownhart: Mr. Speaker: Under date of September 9th, your Secretary, acting for the Committee, addressed the following communication to the President of the University:

9 September 1932

Hon. Glenn Frank,
President,
University of Wisconsin,
Madison, Wisconsin.

Dear President Frank:

There goes forward, with this letter, eighteen copies of the report of the special committee of this Society to study admissions to the State of Wisconsin General Hospital and eighteen copies of the report of our special committee on the Distribution of Medical Services in this state. We are happy to forward these to you for the use of the Regents. Additional copies will be furnished promptly in event that you need them.

I was indeed happy that we had the opportunity of presenting to the Executive Committee and the Medical Committee of the Regents the general situation with respect to the state hospital and the basic recommendations of our Committee. I am indeed hopeful that this joint study will prove to be of value.

At the conclusion of our meeting, it was our understanding that:

1. We may report to the House of Delegates that recommendation number two of the report of our Special Committee on the hospital will be adopted by the hospital authorities with the possible exception that they may propose some change in the wording that we used to designate what has heretofore been known as the clinic patient. While our Committee feels keenly that the definition it proposes is a proper one, I do not understand that they will object to a change in wording which accurately conveys the terms under which the service is being rendered. Dr. Bardeen, as I recall, believed that the present designation "clinic case" was sufficient. While this may have been sufficient some years past, the popularization of the pay clinic has given the term a public usage which no longer, to our minds, makes it a fitting term to designate the semi-indigent case. It is my understanding that in event that the hospital authorities desire to make a substitution of terms that we will be apprised of such suggestions prior to the meeting of the Board of Regents on October 12th.
2. Having in mind your suggestion that we outline the needs for such further studies and factual findings as will be helpful to the Regents, I believe that I speak for the Committee when I suggest that in the matter of private patients we are solely concerned with the principle involved and that no additional studies suggest themselves to us at this time.

3. In the matter of the so-called state case (the joint state and county charge), we agree with you that our recommendation involves in part a change of state policy which may be effected only by the legislature. I believe that it will greatly simplify any legislative presentation of this subject matter if it is not confused with our other recommendations and I am happy to know that the Regents will pass on those which fall entirely within their jurisdiction when they meet on October 12th.

Having in mind, however, that Doctor Buerki raised the point that he had made a study of five hundred state cases to ascertain what percentage might have been cared for adequately in local institutions under local care with the exception that such local institution would be a fifty bed hospital and that the physician would be a general practitioner doing his own surgery, we would venture to suggest that this study is hardly helpful. We doubt whether there is time before the Regents meet on October 12th to make further studies along this line because of the fact that the present hospital records as to state cases do not appear to lend themselves readily to this purpose. When the time is available, however, and in event that the Regents would like to have the information, it would be our suggestion that the hospital authorities review the 752 individual admissions from Dane county; the 63 individual admissions from Fond du Lac county; 70 individual admissions from Marathon county; 2 individual admissions from Milwaukee county; 326 individual admissions from Racine county, and the 256 individual admissions from Rock county in the last fiscal year, with the view of ascertaining how many of these cases required a specialized treatment which was not available in their local institutions and under their local physicians. We do not feel, however, that this study is essential to an adequate discussion of our recommendations before the Board of Regents.

May I express, President Frank, my personal appreciation for the opportunity to meet with you this morning.

With kind personal regards,

Cordially and sincerely yours,

J. G. CROWNHART,
Secretary.

Speaker Seeger: Dr. Jackson, does this complete your report?

Chairman Jackson: Yes.

Speaker Seeger: The report of the Committee which you have just heard is now open for discussion for the information of the Resolutions Committee, to which it will be referred.

Delegate C. D. Boyd (Kaukauna): Mr. Speaker: It occurs to me that some misleading ideas may have been gathered from the figures expressed in this report with reference to the expense to the different counties.

In my county, the expense to the county is put in as $6,000, in paying for these public cases. Some investigations that were made in our county show the cost of the transportation of the patient and the accompanying parties who took these patients to the state hospital, with the proportion of the State Aid that this individual county paid, amounted to some $16,000, instead of $6,000.

If we had that information, even approximately, which I think could be obtained, it might be of value in influencing our local officers, in possibly bringing some of those patients to our local hospitals.

Speaker Seeger: Does someone else wish to discuss this? Are there any questions which you wish to ask Dr. Jackson at this time.

Alternate Delegate H. F. Fredrick (Westfield, Columbia County): I wish for information on this matter with regard to whether there was an intent by either Committee to keep the subject matter of those two reports from the general membership? Was there any intent? There is a large number of members that do not know anything about either one of those reports. The delegates and the officers have received the reports, but very few groups met after the time, and we were promised that the reports would be in our JOURNAL sixty days before this meeting.

There has been some suspicion, and there has been some question in regard to whether that was the intent, . . . that this matter would be kept from the information of the members, I do not refer now to the delegates, because the movement did not start with the delegates, it started with the members, and it has been repeatedly tried, and attempts have been repeatedly started to get this thing threshed out.

I wish to know whether, if we accept these Committee reports, it precludes any discussion as to their acceptance by the Board of Regents? If we accept these Committee reports, are we then bound not to find fault with the other end of it? That is, if the Board of Regents has not accepted these very fair findings, is there anything bearing upon us that we should not accept it? The labor that has been expended upon this report cannot be repeated, and still keep the medical profession in good feeling.

The report was accepted unanimously by that committee the seventeenth day of July and at that time President Frank was informed of this, and it has been two months since that time.

If there is any possibility of their annulling this piece of work we have been doing, we are going to get ourselves into a great deal of trouble. Certainly the Board of Regents have had more time to consider this than we have, and they have, I won't say as able, or more able or less able attorneys that they have listened to.

I wish to make a motion bearing upon this, and desire further information, to see if it precludes a motion after we have accepted that report.

Dr. John J. McGovern: Why cannot this report be made to cover the whole state? The abuses in the County Hospital in Milwaukee County are very,

very many, and very great. Why cannot we investigate all of the public hospitals, county and state? Why single out the Wisconsin General Hospital alone for this investigation?

President-Elect Jackson (Chairman of the Committee): Replying to the previous speaker, the whole thought on the part of the Committee when the report was completed was to send it, as we did, to the delegates and to the county society officers, with the thought and understanding that they would call their county societies together and read the report. Many of them did this.

Several county secretaries called me on long distance phone, and were not quite clear in their minds if they had this right. I said, "It was all for your benefit that the Council appointed this Special Committee." County societies were then meeting and taking action and sending their delegates instructed before they had accurate information.

The whole thought of your Committee was to find out the facts and present them, and let the county societies do as they wished. I am sorry if I failed as chairman . . . I thought that was understood. Was not that your understanding, Mr. Crownhart? (Yes)

Dr. Gilbert E. Seaman (Chairman, Special Committee on Distribution of Medical Services in Wisconsin): The gentlemen referred to both reports.

In connection with the report on Distribution of Medical Services, I will say that it has only been within the last very few days that the report on Contract and Panel Practice has been ready for distribution, so that the report of that Committee could not have been made in time to send it to the entire membership of the Society, if, indeed, that were the procedure to be followed.

However, it has been in the hands of the delegates, the officers, the Councilors, and I think, the officers of county medical societies. Is that a fact, Mr. Secretary? (Yes)

There are things in that report that it was highly desirable to discuss and to thresh out within the Society before it was given to the public. The report is submitted in this form, will be referred, and will be brought before the Society, as I understand it, at a subsequent session for discussion.

Delegate H. T. Barnes (Delafield): I read those reports thoroughly, through and through, and I read the note on keeping them confidential, but I did not take it that it was to be kept secret from the members of the Society at all. I took it that it was not to be published and given out to the laity. Understanding it in this way, I asked the President of our Society to call a meeting to discuss these very reports, and that is just what we did.

It was put up to our County Society for discussion and they were warned not to make it public. That is the way I took it.

Speaker Seeger: Dr. Fredrick, have your questions relative to this point been answered?

Dr. Fredrick: I wish to get the expression of the intent. I believe the intent was correct, but I wanted to have this expression.

Speaker Seeger: Are there any other questions, or is there any other discussion?

Delegate E. W. Miller (Milwaukee): If my memory serves me correctly, one of these committees asked for more time in which to complete its study of some of these subjects. That being the fact, I ask why we make any resolutions as to the completion of at least one of the studies which are now under way. I think we would be entirely out of order in referring this thing to any Resolutions Committee unless the Committee which submitted this report is thoroughly confident they have completed the study of whatever they have undertaken.

Dr. John J. McGovern: I would like to offer some resolutions.

Speaker Seeger: Dr. McGovern, the order of the day is that resolutions, unless they refer to the matter which we are discussing at the present time, may not be presented until later.

Dr. McGovern: These are along the lines of matters you have been discussing. A great deal of work has been done to get the medical man to take splendid care of the public, but nothing, or less than nothing, has been done to take care, any care whatever, of the medical man. That is the fellow I am interested in.

Speaker Seeger: Dr. McGovern, if your resolutions do not refer to the reports of these Committees, they are out of order now, but I would be very glad to have you present them later.

Dr. McGovern: I may present them later?

Speaker Seeger: You may. I will be very glad to call upon you.

Dr. Miller has raised a point of order relative to the submission of the report of these Committees to the Committee on Resolutions.

The By-Laws state that the Committee on Resolutions shall receive reports of Special Committees, and the reports have been submitted officially by these Committees.

The fact that the Committee feels that further investigation along certain lines may be necessary, does not preclude the consideration of these reports by the Resolutions Committee, and by this House, which may or may not concur in the recommendations of these Committees, based on the work which they have done up to this time. Unless there is objection to my ruling, I will rule that they shall be referred to these Committees.

Is there any other discussion at the present time of this matter? Or any other questions?

Delegate F. F. Bowman (Madison): It would seem from the reading of this report that this is a completed report. The other reports, as represented, are reports of progress. I do not see anything in this report which says that the Committee desires to go on and continue further study of the subject, but that these are the completed findings of this Committee. And, if my interpretation of this report is correct, it would seem to me that it

was proper for this body to act upon this at this time.

Dr. Seaman: To which particular report does Dr. Bowman refer?

Dr. Bowman: I refer to the report of the Special Committee on Admission of Patients to the General Hospital of Wisconsin. They have presented this report as complete. The other reports say "Progress Report of Special Committee," and "Supplemental Report of Special Committee." But this would appear to be a completed report ready for action by the House of Delegates in the State Medical Society.

President-Elect Jackson (Chairman, Special Committee on Admissions to the State of Wisconsin General Hospital): I think, Dr. Bowman, if you will look in the report you will see it ends up by asking the House of Delegates to authorize us to present this matter to the Board of Regents. That is the way it reads.

Delegate F. A. Thompson (Milwaukee): Mr. Speaker, it seems to me there is a little running around on the subject here tonight.

As I looked over the reports, there are several conclusions we should arrive at,—whether we want to go on with this particular committee and whether the committee has reached, in certain phases of its work, conclusions on which we can act. And in view of this, I should think that the Committee on Resolutions should have the authority, or it should be more or less instructed, to bring the conclusions to us in such form that all of this House of Delegates will understand exactly upon what they are acting.

Speaker Seeger: In order to clear up in the minds of any of you the procedure relative to the handling of these reports, I should like to read to you Sec. 4 of Chapter III of the By-Laws of this organization:

> "From among members of the House of Delegates the Speaker of the House of Delegates, for the purpose of expediting proceedings, shall appoint Reference Committees to which reports and resolutions shall be referred as follows:
>
> "a. On Credentials.
> "b. On Resolutions.
> "c. On Reports of Officers.
> "d. On Reports of Standing Committees.
>
> "He shall also appoint such other committees as may be considered by him to be necessary."

It seemed to me, and to the officers of this Society, that discussion of this important matter would be facilitated by having presented to you the reports of these chairmen, and to have them discussed informally for the information of the Resolutions Committee,—to have them referred to the Committee in accordance with the By-Laws and then to have the Committee formulate a set of recommendations for your adoption or rejection, or amendment, at the meeting tomorrow evening.

If that does not meet with your approval, it is within your power to request that this be taken out of the hands of the Committee on Resolutions, and it requires a two-thirds vote in order to do so.

Alternate Delegate H. F. Fredrick (Westfield): Mr. Chairman, is it not true that all resolutions should be filed tonight?

Speaker Seeger: So far as possible we would like to have the resolutions tonight, but the Resolutions Committee will also accept resolutions tomorrow evening, or at the Thursday session.

Delegate H. J. Gramling (Milwaukee): I am a little of the opinion of Dr. Thompson. He stated a moment ago there is a good deal of misunderstanding among the delegates as to what this report means, because it was astonishing that this important report, on which this Committee spent so much time and money, should have so little discussion. There are probably many members here who are not informed of just what it means. Perhaps many delegates feel like I do. I am not quite clear. If the gentleman would restate his proposition, it might invite some discussion, and when the Committee on Resolutions makes its report tomorrow night we would be able to discuss it very intelligently.

I think there has not been enough discussion of this important report. It is one of the most important reports that has ever come before the House of Delegates of this Society.

Dr. Rock Sleyster (Wauwatosa, Treasurer): It is customary to accept parliamentary procedure in matters of this kind, and for the introduction of resolutions at the first meeting of the House of Delegates. These are referred to reference committees. Any member especially interested in these resolutions may have, and should have, the privilege of appearing before the reference committee while the resolutions are under consideration.

The resolutions are brought back by the reference committee, and it is at this time that the subject matter is open for general discussion. It seems to me we are wasting a lot of time tonight because tomorrow night at the time of the report of the reference committee is the time for general discussion of these matters.

I think the reference committee should announce the time and place of their meeting so that those especially interested could appear before them.

Speaker Seeger: If there is no further discussion I will ask Dr. Carter, in accordance with Dr. Sleyster's suggestion, to state at what time and place his Committee will meet so that those who are interested can appear there with any suggestions they may have.

Delegate R. M. Carter (Green Bay, Chairman of Resolutions Committee): We had intended to have a meeting tonight after this meeting, but in view of the important matters that will come before the Committee, I think that we should start that meeting at nine in the morning, and we can find out just where we can hold it.

Secretary Crownhart: Dr. Carter, if it is agree-

able to you, I will announce now that the place of your meeting will be Room B, on this floor. Room B will be available at nine o'clock tomorrow morning.

Mr. Speaker, did I understand from Dr. Bowman he wished to discuss the report of Dr. Seaman's Committee before we rose from executive session?

Dr. F. F. Bowman (Madison): I think Dr. Seaman was discussing the contract and panel service. There is just one point I want to bring out in this report. I was particularly interested in the part of the report that referred to the discouragement of vaccination by health departments, and I was rather sorry to see they had taken the attitude that this should be discouraged except in cases of emergency.

I know that the practice with regard to this in various communities differs very widely, but I have personally felt that in order to be of any value to any community, a vaccination program must be a mass proposition and carried on as such. In time of peace they say it is the proper time to prepare for war, and when the emergency is on many of these practices are of no avail.

Reference has been made to the program as put on by Dr. Henry F. Vaughan of Detroit, in which he employed exclusively, I believe, the private physician in the administration of diphtheria prevention. It is a very well thought out program and evidently a very successful program, but when we consider the cost that it came to, in the community, that is another matter. If communities are able to meet this, it would be very fine and I am sure that every one who is interested in the furthering of public health would be exceedingly glad to have the private practitioner take this over entirely.

But when you consider the cost to the city of Detroit, if I am correct in my memory I think it was over $250,000 that was necessary to carry such a program into effect, I think you will find when you get into amounts of that kind in your private community you are going to meet with nothing but discouragement.

I would like to see that part of the report left open so that the individual county society might be at liberty to act as it saw fit.

I speak of this because in my own county I have found the medical society has taken a very liberal and broad attitude toward a program of this kind. In fact, the Dane County Medical Society voted unanimously to carry on a free vaccination program, not only for smallpox, but for diphtheria, and they did venture out into the smallpox campaign and did very well. But they realized when it came to carrying on a diphtheria program which meant the return of the patient for three treatments, they had taken on a rather large contract, and they referred the whole program to the Health Department to carry out.

It has become quite a general practice, and while we encourage and try in every way to have people go to the private physician to have this work done, there is only a small percentage that will take advantage of it. It has developed into a condition where many of the private physicians now refer their patients to the Health Department for this sort of treatment.

I bring this up as a suggestion, because I realize that this problem is one that will meet with a different solution in most every community, and will be guided very largely by local circumstances. I should not like to see a Committee report adopted which precluded the opportunity of a community putting on a campaign for this sort of protection.

It is an enormous amount of work to bring this to the attention of the public, and to get the individual interested. You have to enlist to all sorts of private aid, and all sorts of organizations, and such auxiliary organizations as we heard of this evening have been extremely helpful; and then it comes in as a mass proposition. Where there is no objection on the part of the community, I would like to see the different localities given the opportunity to decide as to their own program with regard to this work.

Dr. Gilbert E. Seaman (Chairman, Special Committee on Distribution of Medical Services in Wisconsin): Mr. Speaker, of course this report has not the effect of law. It is not mandatory upon any community or upon any individual. It will not be if it is adopted by this Society.

The recommendation referred to by Dr. Bowman is in line with the present trend of thought in the medical profession . . . that is, that one of the fields still left to the general practitioner of medicine is the field of preventive medicine. Also, that it is not the function always and everywhere for the health departments to practice medicine. Nor is it the function for states, or cities, or corporations to practice medicine.

We are encouraging the general practitioner, the medical man, to interest himself in preventive medicine. We say that preventive medicine is more important than curative medicine. If that is so, then I think any report on this subject at this time (if that, indeed, is the generally accepted idea of the medical profession of America) should at least point out the fact that it is the function of the medical man to practice preventive medicine, in so far as he can do so effectively.

That is the purpose of that particular recommendation.

In reference to the matter of the program of the Health Commissioner of the city of Detroit, or any other reference which we make in the report, we merely make those references by way of some authority for the conclusions or for the recommendations which we make. As to whether vaccination in the city of Detroit cost $250,000, more or less, or how much it might cost anywhere else, that is aside from our function.

This report relates to matters concerning the practice of medicine and not so much to matters of meeting situations where situations have to be met,

or to the matter of whether the expenditures involved are justified or not. (Applause)

Speaker Seeger: The reports will be referred to the Committee on Resolutions which will meet in Room B, tomorrow morning at nine o'clock. Its report will be given to this House for final action tomorrow evening.

I will now entertain a motion that we rise from executive session.

Alternate Delegate H. F. Fredrick (Westfield): I have a resolution to present.

Speaker Seeger: You may present it this evening, and I will call on you to do it at the proper time. In the regular order of business it comes in just a little while.

. . . Motion was made by Alternate Delegate Lotz of Milwaukee that the House of Delegates rise from executive session. The motion was seconded by Delegate F. A. Thompson of Milwaukee, and carried . . .

NOMINATING COMMITTEE

Speaker Seeger: The next order of business is the election of the Nominating Committee of the House. In accordance with precedent, I will ask the Secretary to read the names of the Societies in each component district, and as these are read, the delegates from that district will please rise and I will call them to nominate one of their members as the member for the Nominating Committee.

Secretary Crownhart: The First District comprises Dodge, Jefferson and Waukesha County Societies.

Speaker Seeger: Will those members please rise, and nominate one among themselves to be on the Nominating Committee?

. . . H. T. Barnes, Delafield, was nominated . . .

Secretary Crownhart: Second District comprises Kenosha, Racine and Walworth County Societies.

. . . G. F. Adams of Kenosha, nominated H. B. Keland of Racine . . .

Secretary Crownhart: The Third District comprises Dane, Columbia, Green, Rock and Sauk County Societies.

. . . L. V. Littig of Madison, nominated J. F. Mauermann of Monroe . . .

Secretary Crownhart: The Fourth District comprises Crawford, Grant, Iowa, Lafayette and Richland County Societies.

. . . C. A. Armstrong of Prairie du Chien nominated George Parke of Viola . . .

Secretary Crownhart: The Fifth District comprises Calumet, Manitowoc, Washington–Ozaukee and Sheboygan County Societies.

. . . H. M. Lynch of West Bend nominated R. C. Meyer of Plymouth . . .

Secretary Crownhart: The Sixth District comprises Brown–Kewaunee, Door, Outagamie, Fond du Lac and Winnebago County Societies.

. . . C. D. Boyd of Kaukauna nominated D. J. Twohig of Fond du Lac . . .

Secretary Crownhart: The Seventh District comprises Juneau, La Crosse, Monroe, Trempealeau–Jackson–Buffalo and Vernon County Societies.

. . . C. F. Peterson of Independence nominated Gunnar Gundersen of La Crosse . . .

Secretary Crownhart: The Eighth District comprises Marinette–Florence, Oconto and Shawano County Societies.

. . . A. J. Gates of Tigerton nominated G. R. Duer of Marinette . . .

Secretary Crownhart: The Ninth District comprises Clark, Green Lake–Waushara–Adams, Lincoln, Marathon, Portage, Waupaca and Wood County Societies.

. . . H. H. Christofferson of Colby nominated R. W. Jones of Wausau . . .

Secretary Crownhart: The Tenth District comprises Barron–Washburn–Sawyer–Burnett, Chippewa, Eau Claire and Associated Counties, Polk and Pierce–St. Croix County Societies.

S. O. Lund of Cumberland nominated R. G. Arveson of Frederic . . .

Secretary Crownhart: The new Eleventh District comprises Douglas, Ashland–Bayfield–Iron County Societies.

. . . J. M. Dodd of Ashland nominated T. J. O'Leary of Superior . . .

Secretary Crownhart: The Twelfth District comprises The Medical Society of Milwaukee County.

. . . F. A. Thompson nominated H. J. Gramling of Milwaukee.

Secretary Crownhart: The new Thirteenth District comprises Oneida-Forest-Vilas, Langlade and Price-Taylor County Societies.

. . . G. E. MacKinnon of Prentice nominated I. E. Schiek of Rhinelander . . .

Speaker Seeger: I will ask the Secretary to read the list of nominees.

Secretary Crownhart: Mr. Speaker, the nominees if accepted by the House presently will be:

Dr. Barnes of Delafield,
Dr. Keland of Racine,
Dr. Mauermann of Monroe.
Dr. Parke of Viola,
Dr. Meyer of Plymouth,
Dr. Twohig of Fond du Lac,
Dr. Gundersen of La Crosse,
Dr. Duer of Marinette,
Dr. Jones of Wausau,
Dr. Arveson of Frederic,
Dr. O'Leary of Superior,
Dr. Gramling of Milwaukee,
Dr. Schiek of Rhinelander.

This Nominating Committee will meet at the Secretary's desk, immediately at the conclusion of this House of Delegates.

Speaker Seeger: A motion is now in order that this Committee, as read, will constitute the Nominating Committee of this House.

Delegate D. E. W. Wenstrand (Milwaukee): Mr. Speaker, I move that the Committee, as read, con-

stitute the Nominating Committee of this House of Delegates.

. . . The motion was seconded by Delegate J. O. Dieterle of Milwaukee and carried . . .

COUNCILOR ELECTION

Speaker Seeger: We will now proceed to the election of Councilors. In accordance with precedent, Councilors are elected by the House as a whole, but the nominations are made by the individual districts affected. Taking each district separately, I will ask the Secretary to read the roll of counties and then the delegates from these districts, which are four in number, will caucus for five minutes.

The nomination of the caucus does not preclude other nominations by the House at large or by individuals from that district.

The districts affected are the Seventh, Councilor to succeed Dr. Spencer D. Beebe of Sparta; Eighth District, to succeed Dr. T. J. Redelings of Marinette; Ninth District, to succeed Dr. Joseph F. Smith of Wausau, and the Tenth District, to succeed Dr. H. M. Stang of Eau Claire.

Secretary Crownhart: Mr. Speaker: The Seventh District consists of Juneau, La Crosse, Monroe, Trempealeau–Jackson–Buffalo and Vernon County Societies. The Eighth District consists of Marinette–Florence, Oconto and Shawano County Societies. The Ninth District consists of Clark, Green Lake–Waushara–Adams, Lincoln, Marathon, Portage, Waupaca and Wood County Societies. The Tenth District consists of Barron–Washburn–Sawyer–Burnett, Chippewa, Eau Claire and Associated Counties, Polk and Pierce–St. Croix County Societies.

We also have to elect, Mr. Speaker, a Councilor from the new Thirteenth District, so I will ask any members from Oneida–Forest–Vilas, Langlade and Price–Taylor County Medical Societies to meet also at this time.

Speaker Seeger: Do you understand your instructions? The House will recess for five minutes.

. . . Recess of five minutes . . .

Speaker Seeger: We will now receive the nomination from the Seventh District for Councilor.

Delegate C. C. Vogel (Elroy): The members of the Seventh District unanimously nominate Spencer D. Beebe to succeed himself.

Speaker Seeger: If there are no other nominations, the nominations will be closed, and I will entertain a motion to declare Dr. Beebe unanimously elected for the office of Councilor from the Seventh District.

. . . Motion was made by Delegate Gunnar Gundersen of LaCrosse that Dr. Spencer Beebe be declared unanimously elected for the office of Councilor from the Seventh District. The motion was seconded by Delegate C. F. Peterson of Independence and carried . . .

Speaker Seeger: We will now receive the nomination from the Eighth District for Councilor.

Delegate A. J. Gates (Tigerton): The members of the Eighth District unanimously nominate Dr. G. R. Duer of Marinette as Councilor.

Speaker Seeger: Are there any other nominations? If not, I will declare the nominations closed, and I will entertain a motion to declare Dr. Duer unanimously elected for the office of Councilor from the Eighth District.

Dr. T. J. Redelings (Marinette): Mr. Speaker, it gives me great pleasure to endorse this nomination and to commend Dr. Duer to the Council. He is a worthy member of our profession and eminently qualified, right-minded, and in every way will make an acceptable Councilor. I want to thank the members of Oconto and Shawano and Marinette and Florence Counties for relieving me of this duty. During the course of the summer I visited each Society and requested that I be replaced.

I am pleased to second the nomination of Dr. Duer. (Applause) I move that Dr. Duer be declared elected.

Speaker Seeger: Dr. Redelings moves that nominations be closed and the Secretary instructed to cast the unanimous ballot of this House for Dr. Duer for the office of Councilor from the Eighth District.

. . . The motion was seconded by Delegate W. R. Berg of Gillett and carried . . .

Speaker Seeger: We will now receive the nomination from the Ninth District.

Delegate R. W. Jones (Wausau): The Ninth District nominates Dr. Joseph F. Smith of Wausau to succeed himself.

Speaker Seeger: Are there any other nominations? If not, I will declare the nominations closed, and I will entertain a motion to declare Dr. Smith unanimously elected for the office of Councilor from the Ninth District.

. . . Motion was made by H. H. Christofferson of Colby that Dr. Joseph F. Smith be declared unanimously elected for the office of Councilor from the Ninth District. The motion was seconded by Delegate F. X. Pomainville of Wisconsin Rapids and carried . . .

Speaker Seeger: We will now receive nominations from the Tenth District.

Delegate F. E. Butler (Menomonie): The Tenth District nominates Dr. H. M. Stang to succeed himself.

Speaker Seeger: Are there any other nominations? It not, I will declare the nominations closed, and I will entertain a motion to declare Dr. Stang unanimously elected for the office of Councilor from the Tenth District.

. . . Motion was made by Delegate A. E. McMahon of Glenwood City that Dr. H. M. Stang be declared unanimously elected for the office of Councilor from the Tenth District. The motion was seconded by Delegate H. J. Gramling of Milwaukee and carried . . .

Speaker Seeger: We will now receive nominations from the Thirteenth District.

Delegate R. M. Carter (Green Bay): I will

nominate from the floor Dr. I. E. Schiek of Rhinelander.

Speaker Seeger: Are there any other nominations? If not, I will declare the nominations closed, and I will entertain a motion to declare Dr. Schiek unanimously elected for the office of Councilor from the Thirteenth District.

. . . Motion was made by Delegate T. J. O'Leary of Superior that Dr. I. E. Schiek be declared unanimously elected for the office of Councilor from the Tenth District. The motion was seconded by Delegate J. C. Wright of Antigo and carried . . .

Secretary Crownhart: For the information of Dr. Schiek and Dr. Duer, the Council meets tomorrow at five-thirty in Room B on this floor.

REPORT OF PRESIDENT

Speaker Seeger: At this time the Speaker will call on our President, Dr. Otho A. Fiedler to hear from him relative to some suggestions and recommendations for the future conduct of this Society. (Applause)

President Fiedler: I need not call your attention to the fact that the present economic situation with its attendant disturbances of many social movements, has brought the question of the distribution of medical service to the forefront in relief considerations. Anticipatory of this, I suggested a year ago that a survey, fact finding in nature, should be made in this state with the idea of laying the foundations upon which we might build some concrete plan to meet what has become an evident social need. The reports of such committees as have been investigating this matter are to come before you, but the work is not completed.

(1) It is therefore my recommendation that in the year to come this work be continued under the committee already in existence, giving special attention to the following:

a. The field of operation, the extent and kind of service, and the classes to which extended by voluntary organizations operating in Wisconsin.
b. A further investigation of the care of the indigent with the view of relieving the medical profession of an onerous, social and economic burden which is out of proportion to anything contributed by any other group of citizens.
c. Cooperation with efforts about to be instituted by the American Medical Association in a study of insurance methods as a possible means of solving these economic problems of the distribution of medical service.

(2) On the scientific side I should urge that we give every assistance and full whole-hearted cooperation to the Cancer Committee that this work may be furthered and an attempt made to lessen the growing mortality from this disease.

(3) The maintenance of the present schedule of dues of the Society and the continuance of the work which has been done by your officers, the more necessary under the present business depression. It is quite evident that the many projects vitally important to the profession cannot be adequately and advantageously handled to the benefit of the profession at large except as we have the necessary means with which to carry on the work. Cutting the budget would be poor economy.

(4) And finally, speaking from my knowledge of conditions, I believe that it would be well that there should be set up in the budget an expense account for the President of your Society to cover actual travel expense, stenographic service, correspondence costs, etc., incident to the conduct of this office. It is altogether probable that most of the men in the past and, so far as we can see, those in the future may not draw upon this account, but it is possible that at some time some member will be elected President, to whom the expense incident to the office would be a burden, and I suggest an appropriation of $500 to be set up in the budget to be used at the discretion of the President for actual and necessary expenses incident to the conduct of the affairs of that office.

Now, if I may suggest one word more, particularly to those men who have so very ably conducted these investigations—the Special Committees, on the hospital, particularly the Committee with which I have worked on the distribution of Medical Service to the State of Wisconsin—it would have been very easy to have failed in this matter, in this study.

It would have been very easy possibly to have gone afield and gotten nowhere. I think the work which this Committee did has been outstanding, and will be recognized as such in time to come, and I want to express to this Committee, particularly, my appreciation of the service they have rendered and to the general body of the profession, the very hearty cooperation which I have always had in all the work that I have done during my term of office. Thank you. (Applause)

REPORT OF PRESIDENT-ELECT

Speaker Seeger: Dr. Fiedler's recommendations, because they largely refer to the budget, will be referred to the Committee on Resolutions.

Under the Constitution, Committee appointments of the President-Elect must be confirmed by the House. For that purpose, and to hear of any suggestions you may have for your Society's future, I will now call upon you, Dr. Jackson. Dr. Reginald Jackson of Madison, your President-Elect. (Applause)

President-Elect Jackson: Mr. Speaker, and Members of the House of Delegates: Your deliberate action a year ago, in electing me incoming President of the Society deserves, on my part, an expression of gratitude for the signal honor thus conferred.

While at the time I was duly impressed with the honor, I am at present overwhelmed with the sense of responsibility. During the past year I

have been made aware through attendance at meetings of the Council, the Committee on Public Policy, and as chairman of a special committee, of the constantly increasing perplexities and problems which confront our profession. From various hints given me by my predecessors in office, I now anticipate not only a year of honorable distinction but one filled also with arduous work and worry.

However, this is as it should be and, if I am not mistaken, will be the lot of my successors in office for many years to come. It must be apparent to all of us that if we, as a profession, are to maintain our position and hope to better it, such end can be attained only through eternal vigilance, thoughtful foresight and united action.

The day of our individualism has gone. We must develop a stronger sense of unity not only for ourselves but for those who are to follow us. The strength of the wolf lies in the pack and it is time we realized that many of the forces which assail us are unwittingly grouping themselves together in this fashion.

I am convinced that there is inherent in the membership of our Society all the resources of wisdom, courage and ability essential to solve the problems before us.

The constructive recommendations which Dr. Fiedler has offered meet with my approval. I shall make only one suggestion at this time.

Many of our problems and perplexities are associated with the activities society resorts to in its humanitarian efforts to relieve physical suffering. There is at times on the part of society and its agents a fundamental lack of understanding of the motives which actuate us in our attitude towards some of these activities. Doubtless, at times, our profession also fails to sympathetically comprehend the problems and motives of some of the agencies engaged in public preventive medicine and other fields.

I should like to see established in this state a far closer liaison than exists at present between the private practitioner of medicine and all other organizations, public or philanthropic, which have to do with any phase of health.

There already exist in this state all the physical requirements and personnel essential to care for the health problems of the population in a satisfactory way. To insure harmonious cooperation there should be an annual meeting of minds of those interested in the various phases—a voluntary Bureau of Correlated Health Activities—composed of the permanent secretaries, the active and past presidents, and the councilors of all the existing present agencies, a forum at which many perplexing questions could be presented and intelligently solved to the mutual advantage of society and organized medicine. Unless organized medicine occupies a central position and serves as a socially sympathetic guiding influence in molding the pattern of things medical, the medical profession of this state will inevitably become steadily more subservient to lay supervision under political domination.

To put into effect this suggestion will place an additional burden upon the shoulders of our Secretary. Based upon my personal observation during the past year, I should like to pay a sincere tribute to his work and personality. If I had been asked two years ago what I thought of him, I would probably have replied, "Oh, George is a good fellow," and let it go at that, thus betraying my own delinquency in failing to keep in touch with the many problems which are always on his desk pressing for solution.

Today, I say he is an exceptionally capable man in the right place. I feel that our Society is singularly fortunate in having a man of his training and ability constantly occupying the key position in our organization.

The majority of us are too busy as practitioners to note in the ever changing current of passing events those things which concern us as physicians until they are accomplished facts. I believe that in the future there will arise many situations where foreknowledge on our part of proposed activities by others will provide opportunity for mutual consideration and compromise adjustment, and that a Bureau of Correlated Health Activities with George Crownhart as one of our liaison officers is worth our consideration and effort.

While acting as your President, I am your servant and shall aim to serve the best interests of those you represent.

I am fully conscious of the personal lack of many of those qualities so essential to adequately fill the position to which you elected me. I trust you will individually feel free to extend to me through personal interview or correspondence the guiding influence of your knowledge and matured thought on all problems pertaining to our beloved profession. Of your loyalty, I have no doubt. (Applause)

It is now my duty and pleasure and privilege to read the list of my appointments to the several committees:

Committee on Scientific Work:

Dr. Arnold S. Jackson, Madison, for the term ending September, 1935. To succeed Dr. W. S. Middleton, Madison.

Committee on Public Policy:

Dr. S. E. Gavin, Fond du Lac, for the term ending September, 1935. To succeed Dr. S. M. B. Smith, Wausau.

Editorial Board:

Dr. George H. Ewell, Madison, for the term ending September, 1935. To succeed Dr. Joseph F. Smith, Wausau.

Committee on Medical Defense:

Dr. R. M. Carter, Green Bay, for the term ending September, 1935. To succeed Dr. W. C. Becker, Watertown.

Committee on Medical Education and Hospitals:
Dr. F. D. Murphy, Milwaukee, for the term ending September, 1935, to succeed himself.

Committee on Medical Economics:
Dr. W. G. Riopelle, Beaver Dam, for the term ending September, 1935. To succeed Dr. T. D. Smith, Neenah.

Committee on Health and Public Instruction:
Dr. W. G. Sexton, Marshfield, for the term ending September, 1935. To succeed Dr. C. M. Gleason, Manitowoc.

Advisory Committee on Medical Extension:
Dr. E. F. Schneiders, Madison, for the term ending September, 1935. To succeed Dr. M. D. Bird, Marinette.

Committee on Cancer:
Dr. D. L. Dawson, Rice Lake, Tenth District, to succeed Dr. H. M. Stang, Eau Claire.
Dr. R. L. MacCornack, Whitehall, Seventh District, to succeed Dr. Herman Wolf, La Crosse.
Dr. Cyril G. Richards, Kenosha, Second District, to succeed Dr. F. W. Pope, Racine.
Dr. Gideon Benson, Richland Center, Fourth District, to succeed Dr. E. H. Spiegelberg, Boscobel.
(For the term ending September, 1935.)

Speaker Seeger: I will now entertain a motion that the House approve the appointments of President-Elect Jackson.

Delegate L. W. Peterson (Sun Prairie): I move that the House of Delegates approve the appointments as made by President-Elect Jackson.

. . . The motion was seconded by Delegate L. V. Littig of Madison and carried, without discussion . . .

Speaker Seeger: Dr. Jackson's recommendations will be referred to the Committee on Reports of Officers.

We now come to new business. The House is ready to receive any resolutions. I will ask the delegate to present the resolutions, to come forward and read them. The resolutions will then be referred, without discussion, to the Reference Committee on Resolutions, who will give us their report tomorrow evening.

RESOLUTIONS

Alternate Delegate Fredrick (Westfield): I would humbly ask your forbearance if I have been misinformed. I think my hearing was defective, possibly my judgment. But I have learned in the recess that the subject of my resolution is not necessary. There is no necessity for it, which I am very pleased to know, if that is true. That is, in regard to the clinic cases of that Committee—did the University Regents accept the Committee's recommendation in regard to the clinic cases. I have been told during the recess that was true, and I did not know it until that time; therefore, I have no resolution to offer. (Applause)

Speaker Seeger: Does anyone else wish to introduce a resolution?

Dr. John J. McGovern (Milwaukee): Mr. Speaker, and Members of the House of Delegates: Less than fifty per cent of the sick in Milwaukee County are taken care of by the independent medical profession. A great many surveys have been made, but no concrete suggestions as to what the medical profession can do to get control of the care of the sick, and take it away from the hundred and one rackets.

If you want to care for the sick all you have to do is to organize a little group and grab everything that you can grab, and the medical man does not say a word.

I want to make a concrete beginning in building up the county societies, and do it by having the county society assume all of the work and obligation and responsibility that has been carried by the manufacturer. Why should we stand for the manufacturer practicing medicine?

In order for the county society to do that work they have to make a beginning. Later they can take over the work of the Health Department and put the Health Department where it belongs—in recording statistics and nothing else, and stop the hundreds of industrial nurses from practicing medicine every day.

"Changes in the Law Governing the Industrial Commission. Scale of Compensation." I changed the Industrial law only sufficiently to transfer that work from the manufacturer to the county medical society.

Changes in the Law Governing the Industrial Commission. Scale of Compensation:

Section 102.09. Where liability for compensation under Sections 102.03 to 102.34, inclusive, exists, the same shall be as provided in the following schedule:

Medical Attendance:

(1) a. Such medical, surgical and hospital treatment, medicines, medical and surgical supplies, crutches and apparatus as may be reasonably required for ninety days immediately following the accident, to cure and relieve from the effects of the injury, and for such additional period of time as in the judgment of the Commission will tend to lessen the period of compensation disability, or in case of permanent total disability for such period of time as the Commission may deem advisable, and in addition thereto, such artificial members as may be reasonably necessary at the end of the healing period, the same to be provided by the physician or surgeon in charge of the treatment of the disabled or sick individual; the employer to be liable for the reasonable expense incurred by or on behalf of the employe in providing the same.

b. The employe shall have the right to make choice of his attending physician. (At the present time the law as it exists is unconstitutional and can be broken at any time.) When the employe fails or

neglects to exercise such choice, the county medical society, through its officers or a committee duly selected for that purpose, will select a physician or surgeon from its membership to take charge of the injured or sick employe. It shall be the duty of the employer to notify the county medical society immediately after every accident or injury and to state the nature of the disability and whether this employe has made a choice of physician or not.

c. No change.

d. The county medical society shall assume the responsibility for furnishing a member of the respective county society to treat and care for every employe who comes under this act or who fails or neglects to exercise the choice of physician. The selection of the members of the county society shall be distributed so justly that all of the members who wish to practice industrial medicine will have the same opportunity.

e. The officers of the county society or a committee representing the society shall formulate a schedule of fees agreeable to the employer that will be fair compensation for the medical service and reasonable to the employer. When the society and the employer cannot agree, the disputed point is referred to the Industrial Commission whose decision is final.

f. When in the opinion of the Industrial Commission an attending physician has not impartially estimated the degree of permanent disability or the extent of temporary disability of any injured employe, the Commission shall have the power to cause such employe to be examined by a physician selected by the Commission and to obtain from such physician a report containing his estimate of such disabilities. If the report of such physician shows that the estimate of the attending physician has not been impartial from the standpoint of such employe, the Commission shall have the power in its discretion to charge the cost of such examination to the employer, if he is a self-insurer, or to the insurance company which is carrying the risk.

(2) No change.

a. If the accident causes total disability, seventy-five per cent of the average weekly earnings during the period of such total disability.

b. No change.

c. No change.

Examination by Physicians:

Section 102.13.

(1) Whenever in case of injury the right to compensation under sections 102.03 to 102.34, inclusive, would exist in favor of any employe, he shall, upon the written request of his employer, submit from time to time to examination by a regular practicing physician, who shall be provided by the county medical society and paid for by the employer, and shall likewise submit to examination from time to time by any regular physician selected by said Industrial Commission, or a member or examiner thereof.

The employe shall be entitled to have a physician, provided and paid for by himself, present at any such examination. So long as the employe, after such written request of the employer, shall refuse to submit to such examination, or shall in any way obstruct the same, his right to begin or maintain any proceedings for the collection of compensation shall be suspended; and if he shall refuse to submit to such examination after direction by the Commission, or any member or examiner thereof, or shall in any way obstruct the same, his right to the weekly indemnity which shall accrue and become payable during the period of such refusal or obstruction, shall be barred.

Any physician who shall make or be present at any such examination may be required to testify as to the results thereof. Any physician having attended an employe in a professional capacity may be required to testify before the Commission when it shall so direct and shall receive compensation.

Examination by Physicians:

Section 102.15:

(1) Subject to the provisions of sections 102.03 to 102.34, inclusive, the Commission may adopt its own rules of procedure and may change the same from time to time in its discretion. The Commission, when it shall deem it necessary to expedite its business, may, from time to time, employ one or more expert examiners for such length of time as may be required, such examiners to be exempt from the operation of Chapter 16 of the statutes but not more than one commissioner or expert examiner shall take part in the examination of any case. It may employ such deputies, inspectors, clerks, stenographers and other employes as it may deem necessary. It shall provide itself with a seal for the authentification of its orders, awards and proceedings, upon which shall be inscribed the words "INDUSTRIAL COMMISSION—WISCONSIN—SEAL."

(2) The Commission may provide by rule the terms and conditions under which transcripts of testimony and proceedings shall be furnished.

Dr. McGovern: Here is another resolution. The retail druggists of the state will back any bill of this kind.

> "WHEREAS, The sale of patent medicines that have no medicinal value has reached alarming proportions, the cost to the public amounting to many millions of dollars; therefore, be it
>
> "*Resolved*, That the House of Delegates instruct the legislative committee to have a law drawn preventing the sale of any and all patent medicines that have not been accepted by the Council on Pharmacy of the American Medical Association."

I wish to call the attention of the House of Delegates to the great difference in membership in the State Society in the various councilor districts. The eighth district has thirty-nine members; the twelfth district has 638 members; the first district has 102 members; the third district has 311 members; the fourth district has seventy-six members.

In fairness to the different sections of the state, I think that the House of Delegates ought to reorganize the Council of the State Society and give each district as nearly as possible the same number of members in the State Society. Therefore, be it

"*Resolved*, That the House of Delegates appoint a committee to reorganize the Council."

"WHEREAS, The occurrence daily of automobile accidents in all parts of the state where the automobile or individual responsible for the accident is not insured and possesses no tangible property, and

"WHEREAS, The members of the medical profession who are called upon to take care of the injured individuals are unable to recover any compensation for their time and the expense that they have been put to in relieving suffering and saving life; therefore be it

"*Resolved*, That the House of Delegates instruct the legislative committee to have a law drawn that will compel everyone who owns an automobile to either have it insured or furnish a bond, before the state issues a license for its use."

Changes in the Medical Law:

Another paragraph should be added to 147.14

(4) Practice. No corporation, club or any other association can practice medicine directly or indirectly or organize in any way for the cure or treatment of the sick or injured without coming under the penalties given in this chapter, excepting a county medical society that is authorized to assist in a more efficient organization for the treatment and prevention of disease.

Medical Practice Act:

147.18. Itinerant. To be repealed in toto.

Why should we have wandering physicians going through Wisconsin, doing what they please, for a paltry $200?

147.185. Number to be changed to 147.18 (And the amendment that was added to that bill was 147.185. Those to be changed, to take the number of the bill that is to be totally repealed.)

147.19. Paragraph 2 should be amended to read as follows:

"None of the provisions of this chapter or the laws of the state regulating the practice of medicine or healing shall be construed to interfere with the consolation or mental or physical benefit gained by religious service or prayer by any person belonging to any religious organization; nor shall any person who selects such treatment for the cure of disease be compelled to submit to any form of medical treatment except in the case of infectious diseases or where the individual is in great danger to his life. No person rendering religious or spiritual solace to any person sick or afflicted shall derive any pecuniary benefit directly or indirectly for such spiritual consolation without coming under the penalty for practicing medicine without a license."

There are over eighty Christian Scientists—healers, in the city of Milwaukee, living totally from their humbug. And why should the Christian Scientist be mentioned in the medical law? I cut that out and made it "any religious organization." Put them all on the same footing.

147.13 *Examiners.* (This, your President suggested in one of the last numbers of the JOURNAL, and I have been harping on it for sometime.)

"The governor shall appoint The Wisconsin State Board of Medical Examiners consisting of seven members. The appointment of each member shall be for four years except the first appointment following this amendment. One shall be appointed for one year, two for two years, two for three years, and two for four years. All of said appointees should be licentiates of the Board."

That is to shut out the health department, the corporations—all the rackets.

Everyone of these things can be passed if the medical profession backs them. I thank you. (Applause)

Speaker Seeger: Gentlemen of the House: Some years ago the Council and the House of Delegates amended the Constitution so as to give ex-presidents of the Society the privilege of the floor, in order that we might have the benefit of their experience and profit by their acquaintance with the problems which confront us, and I am sure that I express the sentiment of this House in thanking Dr. McGovern for the amount of time and energy which he has expended in compiling this set of resolutions, which will be referred to the Resolutions Committee.

I think it is fair to state, however, that Dr. McGovern is not a delegate from Milwaukee County, and that some of these problems which may affect local county medical societies have not been passed upon by the local society. I state that without reflecting upon the virtue of any of the measures which he has presented, and merely for the information of the chairman of the Resolutions Committee.

Are there any other resolutions to be presented?

Delegate H. P. Bowen (Watertown): I wish to present an amendment to the Constitution.

Amend Article IX (OFFICERS), Sec. 2 to read:

1. Repeal all of Section 2 as now constituted.
2. Enact Section 2 to read: "Section 2. The President, President-Elect, Speaker and Vice-Speaker shall be elected by the House of Delegates. The Secretary and Treasurer shall be elected by the Council.

"Councilors shall be elected at a meeting of their respective district societies. Notice of election shall be incorporated in a mail notice to members at least seven days before such meeting. Election, where more than one nomination is received, shall be by ballot and a majority of votes cast shall be necessary to elect. Each candidate for Councilor must be a resident of the district which it is proposed that he represent, and no person known to have solicited votes for or sought the office of Councilor shall be eligible for the current election. Other procedure essential to the election shall be governed by Robert's Rules of Order.

3. This amendment, offered in 1932, to be acted upon in 1933, shall, upon adoption, be effective on January 1, 1934.

Speaker Seeger: For your information, I will read Article XIII of the Constitution, relative to amendments.

ARTICLE XIII. Amendments. The House of Delegates may amend any article of this Constitution by a two-thirds vote of the members of the House present at any annual session, provided that such amendment shall have been presented in open meeting at the previous annual session, and that it shall have been published twice during the year in the bulletin or journal of this Society, or sent officially to each component society at least two months before the meeting at which final action is to be taken.

Are there any further resolutions to be offered at this time?

Alternate Delegate P. A. Fox (Beloit, Rock County):

RESOLUTION

"WHEREAS, It appears that under existing conditions we lack adequate means for the distribution of the proper costs of illness as expended by the public; and,

"WHEREAS, This interferes with the delivery of an adequate service in that it does not appear to meet the needs of all the people; and,

"WHEREAS, Medical, surgical and hospital care is and must be individualistic service; and

"WHEREAS, Compulsory health insurance and state medicine tend toward mass treatment and away from that individualistic service and personal relationship so essential between physician and patient; and,

"WHEREAS, It is our belief that the practice of medicine and surgery and hospital care should be by and under the absolute control of the members of the medical profession; and,

"WHEREAS, Compulsory health insurance and state medicine take away this control and supervision; and,

"WHEREAS, To meet this situation many plans are being proposed which upon study appear to be either wholly inadequate or to have evils worse than the situation they seek to alleviate; and,

"WHEREAS, It is our belief that guiding principles or rules for any possible improvement should emanate from the American Medical Association which organization is best equipped to pass upon all the various and important phases involved; therefore, be it

"*Resolved*, That the 1932 House of Delegates of the State Medical Society of Wisconsin in session assembled does respectfully request the American Medical Association to advise this and other component state societies of those principles, in such detail as is possible, under which the organized medical profession may formulate approved plans devised to improve the adequacy of medical service by affording better means for distributing the cost thereof to the public."

Speaker Seeger: This resolution will be referred to the Resolutions Committee.

Are there any other resolutions?

Secretary Crownhart: I have one here by Dr. Dieterle of Milwaukee, which he requested me to read.

Amendment to the By-Laws to provide exemption for payment of dues:

Amendment to Sec. 1, Ch. 8 of the By-Laws, dues and assessments, provide that when a member shall have paid his dues for thirty-five years he shall become a life member and he shall be exempt of further dues and a certificate of membership should be issued to such member unanimously.

Speaker Seeger: This resolution will be referred to the Committee on Resolutions.

Are there any other resolutions? (None)

Any new business?

FOREST COUNTY CHARTER

Secretary Crownhart: I have one last piece of business. In the new Thirteenth Councilor District, one of the present societies is the Oneida–Forest–Vilas Society.

The Forest County physicians have formulated a Forest County Association of Physicians, which includes every physician in Forest County, with the exception of one, which is presently an applicant for membership. They have met twice since June, have effected a permanent organization, with a petition for a charter as a distinct and separate county society, to be known as the Forest County Society. They have elected, in event that meets with your approval, Dr. J. F. W. Clark of Laona as a delegate. This is before you for your approval or disapproval.

Speaker Seeger: I will entertain a motion that

the recommendation of the Council in this matter be approved.

Councilor F. G. Johnson (Iron River): I move that the recommendation of the Council be approved.

. . . The motion was seconded by Dr. F. F. Bowman of Madison, and carried without discussion . . .

Speaker Seeger: Is there any other new business to come up at this time? Mr. Secretary, have you any announcements?

Secretary Crownhart: Mr. Speaker, the House is empowered to select the time of its own sessions after the first. As a matter of convenience, the Secretary, in drawing the program, tries to suggest that time which will not conflict with other sessions of the Society. Unless there is objection, this House will hold its second session in this room at seven-thirty tomorrow evening.

. . . Announcement was made that the members of the Nominating Committee were to meet immediately after adjournment . . .

Speaker Seeger: Is there any other new business?

Delegate R. M. Carter (Green Bay): Mr. Speaker: During the year 1934, the city of Green Bay will celebrate the Three Hundredth anniversary of the landing of the white man in the state of Wisconsin. I have been instructed by the Brown–Kewaunee Society to state to the House of Delegates that we invite the State Society to hold its 1934 meeting in Green Bay. I am giving this to you for your consideration.

Speaker Seeger: Dr. Carter's invitation is received, and we will refer it to the Committee on Nominations, which is the regular procedure.

Is there any further new business? (None)

If not, we stand adjourned until seven-thirty tomorrow evening.

. . . The meeting adjourned at eleven-twenty o'clock P. M. . . .

Adjournment

WEDNESDAY EVENING SESSION

September 14, 1932

The meeting was called to order at seven-forty P. M., by Speaker Stanley J. Seeger.

Speaker Seeger: We will listen to the report of the Committee on Credentials, Dr. Gramling, Chairman.

Dr. Gramling: Mr. Speaker, your Committee on Credentials is pleased to report at this time the registration of thirty-four members of the House, including seven Councilors.

No questions have been raised relative to the seating of Delegates or Alternates.

Slips for recording attendance having been passed out, I move that the attendance record so compiled constitute the roll of this session.

. . . The motion was seconded by Delegate C. F. Peterson of Independence and carried. . .

Speaker Seeger: The roll as indicated will be the official roll call of this House.

The first order of business will be a report by Mr. Crownhart.

Secretary Crownhart: Mr. Speaker, I have a letter from the Secretary of the Vernon County Medical Society, stating that both the delegate and alternate are ill, and asking if we will not seat in this House as a delegate from Vernon County Dr. R. H. Ludden, who is present.

I am also informed that both the delegate and alternate of Grant County are unavoidably detained, and with the approval of the Councilor from that district, we are asked to seat Dr. M. B. Glasier of Bloomington, Secretary of the Grant County Society, as delegate for the remaining sessions. Do these two proposals meet with the approval of the House of Delegates?

Speaker Seeger: The Chair is informed that, unless there is objection from the House, these men may be seated as representing the counties indicated. Will you please state the counties, Mr. Secretary.

Secretary Crownhart: Dr. Glasier, Secretary of the Grant County Society, and Dr. Ludden to act as delegate for Vernon County.

Speaker Seeger: Do I hear any objection? If not I will rule these men shall represent the counties indicated. (No objection)

Secretary Crownhart: Mr. Speaker, with the consent of the House, your Secretary will file the following night letter to Dr. F. C. Warnshuis, Secretary of the Michigan State Medical Society, in convention assembled at Kalamazoo, Michigan.

> "The House of Delegates of the State Medical Society of Wisconsin, assembled in its Ninety-First Anniversary meeting, sends cordial fraternal greetings to the officers and delegates of the State Medical Society of Michigan, assembled in their One Hundred Twelfth Annual Meeting."

Speaker Seeger: The second order of business is the report of the Reference Committee on Reports of Officers, of which Dr. O'Leary, of Superior is chairman.

. . . Dr. O'Leary not being present, the Speaker of the House stated he would call for the report of the Reference Committee on Reports of Officers at a later time . . .

Speaker Seeger: The next order of business is the report of the Reference Committee on Reports of Standing Committees, Dr. Gunnar Gundersen of La Crosse, Chairman.

REPORTS OF STANDING COMMITTEES

Chairman Gundersen: The Reference Committee on Reports of Standing Committees of the 1932 House of Delegates has received the reports and recommendations of the following committees and submits the following report:

1. *Editorial Board.* Committee moves the adoption of the report of the Editorial Board.

Speaker Seeger: The Committee moves the adoption of the report of the Editorial Board. Do I hear a second?

Delegate D. E. W. Wenstrand (Milwaukee): I second the motion.

Speaker Seeger: Is there any discussion?

. . . There was no discussion and the motion was carried . . .

Chairman Gundersen: *Committee on Cancer.* Committee moves the acceptance of the report of the Committee on Cancer.

. . . The motion was seconded by Delegate J. F. Mauermann of Monroe . . .

Speaker Seeger: Is there any discussion?

. . . There was no discussion and the motion was carried . . .

Chairman Gundersen: *Committee on Medical Education and Hospitals.* Committee moves the acceptance of the report of the Committee on Medical Education and Hospitals.

The motion was seconded by Delegate F. A. Thompson of Milwaukee . . .

Speaker Seeger: Is there any discussion?

. . . There was no discussion and the motion was carried . . .

Chairman Gundersen: *Committee on Health and Public Instruction.* Committee moves the adoption of the report with a commendation of the excellence of the work of the Committee.

. . . The motion was seconded by Delegate F. F. Bowman of Madison . . .

Speaker Seeger: Is there any discussion?

. . . There was no discussion and the motion was carried . . .

Chairman Gundersen: *Committee on Medical Defense.* Committee moves the acceptance of the report of the Committee on Medical Defense.

. . . The motion was seconded by Delegate L. V. Littig of Madison . . .

Speaker Seeger: Is there any discussion?

. . . There was no discussion and the motion was carried . . .

Chairman Gundersen: *Committee on Medical Extension.* Committee moves the acceptance of the report of the Committee on Medical Extension.

. . . The motion was seconded by Delegate H. J. Gramling of Milwaukee . . .

Speaker Seeger: Is there any discussion?

. . . There was no discussion and the motion was carried . . .

Chairman Gundersen: In regard to the last, *Committee on Public Policy,* there are two recommendations there in which the Committee does not wish to take any action, but I will suggest the Committee recommends the adoption of this Committee's report with the exception of the following recommendations:

> ¶7 (f) "To repeal that portion of the law which provides that no instructor, stockholder, member of or person financially interested in any school, college or university having a medical department shall not be eligible for appointment to the Board of Medical Examiners."
>
> ¶7 (d) "To provide that the present law requiring first citizenship papers as a prerequisite to licensure be changed to provide for a full citizenship. The Committee moves that this recommendation be given to the House of Delegates for consideration without any specific recommendation from the Committee."

I suggest we clear ¶7 (f) out of the way first and act on the other one separately.

Speaker Seeger: The report of the Committee on Public Policy was printed on pages 560–561 of the August issue of the WISCONSIN MEDICAL JOURNAL, and is familiar to the members of this House.

The Committee on Report of Standing Committees, Dr. Gundersen, Chairman, recommends the adoption of this report with the exception of Par. ¶7 (d), which reads: (Read) and par. ¶7 (f), which reads: (Read)

The question is before you. Dr. Gundersen, do you put that in the form of a motion?

Chairman Gundersen: Yes.

. . . The motion was seconded by Delegate C. A. Armstrong of Prairie du Chien . . .

Speaker Seeger: The question before you is the adoption of the report of this Committee, with the omission of these two pargraphs.

Chairman Gundersen: With the omission of ¶7 (f) particularly, and then I would like to have the House of Delegates act on ¶7 (d) alone. We recommend the adoption of the entire report of the Committee, with the exception of ¶7 (f). We want separate action on ¶7 (d). We want the House to consider that, but we are opposed to ¶7 (f).

Speaker Seeger: Does your Committee wish to submit to the House a report altering ¶7 (f), or do you wish to have the House vote on this with the omission of these two resolutions?

Chairman Gundersen: We want the House to vote on the entire report, including ¶7 (f). We wish discussion of ¶7 (d).

Speaker Seeger: Then I will restate the motion. with the consent of the delegate who seconded it, that the question before us is the adoption of the report of the Committee on Public Policy, as it stands, with the omission of paragraph ¶7 (f). Do you wish to discuss that at this time?

However, Dr. Gundersen, if this report is adopted I do not know what action you can take. I believe, if you wish some discussion of that at this time, we might bring it up now. The question your Committee wishes discussed is whether you wish to have included in this report the paragraph as follows:

> "¶7 (d) To provide that the present law requiring first citizenship papers as a prerequisite to licensure be changed to provide for a full citizenship. The Committee moves that this

recommendation be given to the House of Delegates for consideration without any specific recommendation from the Committee."

Chairman Gundersen: May I discuss that, Mr. Chairman? The Committee was divided in respect to this provision. My personal view being that there was no present necessity of changing that provision in the Medical Practice Act—that it was rather in violation of the spirit on which the entire country had been founded, and we felt there was probably no immediate necessity of making any change.

We would like to know, or would like some information in respect to that. We would like to know how many candidates apply for licensure in the state of Wisconsin every year from foreign countries, whom this might affect.

Secretary Crownhart: Is any member of the State Board of Medical Examiners in the room? (None) Off hand, Dr. Gundersen, lacking authentic information, my belief is that would affect about three a year.

Chairman Gundersen: That is very little isn't it? I do not see that there is any particular necessity of providing full citizenship papers for granting a license in this state at the present time.

I am personally indirectly a beneficiary of the system which provided for first citizenship papers, in that my own father came in and was granted a license after applying for his first citizenship papers, and to make a man who is a graduate of a first class medical school, and meets all the other requirements, wait for five years, I think works a distinct hardship in a state of this kind, made up of a heterogeneous group of nationalities. This is the reason I object to that particular item.

Speaker Seeger: In order to bring it before the House will you move that this item be omitted from the report?

Chairman Gundersen: I move that paragraph 27(d) be omitted from this report.

. . . The motion was seconded by Delegate H. B. Keland of Racine . . .

Speaker Seeger: It has been moved and seconded that the report of the Committee on Public Policy be amended by the omission of paragraph 27(d), which reads:

> "To provide that the present law requiring first citizenship papers as a prerequisite to licensure be changed to provide for a full citizenship. The Committee moves that this recommendation be given to the House of Delegates for consideration without any specific recommendation from the Committee."

Dr. Rock Sleyster (Wauwatosa, Treasurer): I do not think this is proper. I think the Reference Committee should disapprove that part of the report of the Committee, and that should go on record. Then in adopting the report of the Reference Committee it shows the disapproval.

Speaker Seeger: Dr. Gundersen, in presenting it to the House, as I understood it, requested discussion on this point, but did not recommend it be dropped. Apparently, Dr. Gundersen, your Committee were divided?

Chairman Gundersen: Yes, they were divided.

Speaker Seeger: I feel that a motion to amend is in order, and can be made by anyone, whether he is a member of the Committee or not. The question is before you for discussion. Are you ready for the question?

Secretary Crownhart: Mr. Speaker—that I may have it perfectly plain—the Committee on Public Policy does not presently suggest any change in the Medical Practice Act, but when change is made —whether it be in this next session of the legislature or one or two years hence—they ask for permission to make certain changes in behalf of the State Society. One of those changes was to provide that where the present law requires only first citizenship papers, as a qualification for license, it be changed to provide that a man may not have a license in Wisconsin, unless he is a full citizen of the United States. The motion is that that portion of the report be rejected.

Delegate F. A. Thompson (Milwaukee): There is only one contingency I can see that would come up,—a man getting his first citizenship papers might not ever take out his second papers. That was proven during the war time.

Delegate C. F. Peterson (Independence): I am another member of that Committee, and I am the one on the opposite side of the question.

It seems that Dr. Gundersen has explained his position, and I am rather in favor of the recommendation of the Committee as it stands.

Dr. Gundersen says that he has indirectly been a beneficiary through the law as it is now. Perhaps I have been directly a beneficiary, and perhaps should be more grateful for the law as it is than he is, and still when I think that every little town in Wisconsin is being filled with the young graduates that come from our schools, it seems that we are so over-crowded there is hardly any room for any more, and we should cut off and stop somewhere.

It seems the first place to begin is to stop importing doctors from foreign countries. (Applause)

Because we two did not agree on that question I suggested that we neither recommend nor do anything else about that particular part of the Committee's recommendation, but leave it to this House of Delegates to discuss and decide without our recommendation, as to adoption.

With regard to the other section, which asks the repeal of a law or part of a law providing that no instructor, stockholder, or any person interested financially in any of the schools of this state having a medical department, should not be a member of the Board of Examiners: that law should not be repealed. I think the Committee there was unanimous in saying that should be left as it is.

Speaker Seeger: Dr. Peterson, I think you may confuse the House. There is a definite question before them, and I will be very glad to call on you to discuss the attitude of the Committee on section (f) at the time we take that up.

The point we have up to us now is whether this House wishes to amend this report first by dropping paragraph (d), to provide that the present law requiring that first citizenship papers as a prerequisite to licensure be changed to provide for a full citizenship. I will be glad to have you continue your discussion, but I am a little afraid you will confuse the House.

Delegate Peterson: There is nothing further I want to say on that first section, except that Dr. Gundersen and I did not agree, and we decided to leave it to the House of Delegates to decide, without our recommendation.

Delegate J. W. Prentice (Ashland): I think we all recognize that the conditions under which Dr. Gundersen's father and Dr. Peterson came to our state are entirely different from what they are at the present time. With conditions as they are all through the world, we are having an influx because of supposedly financial betterment in this country, which is entirely different than it was at that time. I think they are not to be compared.

As Dr. Peterson says, more men are coming in and taking places from our own citizens, and I am in favor of increasing it to full citizenship.

Question: How do the other states handle this problem? Is Wisconsin alone in taking first papers?

Secretary Crownhart: No, as I recall it, I think perhaps more states accept first papers than require full citizenship. Some states require full citizenship.

Speaker Seeger: Is there any other discussion? Are you ready for the question?

. . . Question called . . .

Speaker Seeger: In order that there may be no confusion, the motion before you is that this provision requiring full citizenship papers, be dropped from the report. Therefore, those who vote "aye" will be in favor of dropping this provision, and those who wish it retained, should vote "no". The question has been stated. Those in favor of dropping this provision will signify by saying "aye"; those opposed "no". The "noes" have it, and the provision will be retained.

Dr. Gundersen, you may proceed with provision #7(f).

Chairman Gundersen: In regard to provision #7 (f), the Committee's recommendation is that that be dropped from the recommendations of the Committee on Public Policy. That provision is as follows:

> "To repeal that portion of the law which provides that no instructor, stockholder, member of or person financially interested in any school, college or university having a medical department shall not be eligible for appointment to the Board of Medical Examiners."

At the present time it is my understanding they are not eligible, and under the new recommendation, which we are opposed to, they would be permitted appointment to the Board of Medical Examiners.

I move that this recommendation #7(f) be deleted from the report of the Committee on Public Policy.

Speaker Seeger: Do I hear a second?

. . . The motion was seconded by Delegate A. E. McMahon of Glenwood City . . .

Speaker Seeger: Dr. Peterson, would you like to discuss that?

Delegate Peterson: That applies particularly to the word "instructor." I do not think you have any medical school in the state of Wisconsin that has a stockholder—I don't know—Marquette may have, people who are financially interested in it, who could be on the Board of Examiners. But outside of Marquette there is no school where this would apply, except instructors.

If you are an instructor in one of those schools and at the same time a member of the Board of Examiners who frame the questions, as well as examine the papers for students that were being instructed or had been instructed by you, there is every chance in the world to favor those students in that examination. Isn't there? They do, even now.

If it were practical to have an instructor on the Board of Examiners, you can see how much that would favor the students of that school, who appear for examination; so I say the law is good as it stands. It is impartial and should be left as it is,—at least so far as it concerns the instructors.

Speaker Seeger: Is there any further discussion on this point? Is the question perfectly clear? At the present time, the law is that no instructor, stockholder, or member of or person financially interested in any school, college, or university having a medical department shall be eligible to the appointment to the Board of Medical Examiners.

The Committee on Public Policy suggests that at the proper time they be given authority to recommend that this law be changed so that these individuals may become members of the Board.

Your Committee on Reports of Standing Committees recommends that the law be allowed to remain as it is, and that this paragraph giving the Committee on Public Policy that authority be dropped.

Are you ready for the question? (Question called)

Those in favor of dropping this paragraph of Section 7 of the report of the Committee on Public Policy will signify by saying "aye"; those opposed.

. . . The "aye" and "nay" vote was not decisive . . .

Speaker Seeger: I will ask for a division of the House. Those in favor of dropping this paragraph will please rise.

Secretary Crownhart: There are nineteen.

Speaker Seeger: Those opposed to dropping this, and allowing it to remain will please rise.

Secretary Crownhart: There are twelve. From the incomplete vote cast, I should judge the question is not fully understood—this time or the time before.

Delegate C. C. Vogel (Elroy): Isn't this on adopting the report of the Committee?

Speaker Seeger: The question before you is the amendment of this report. We have received the report of the Committee on Public Policy, and it has been referred to the Reference Committee on Reports of Standing Committees of the House.

This Committee recommends the adoption of this report, but, it recommends the adoption of this report with certain amendments, and the questions before you now are these amendments—whether or not you wish to amend the report before you finally vote on its adoption, and when you vote on its adoption, you will vote on it as it is amended by you now.

Secretary Crownhart: The Speaker had it entirely correct. The question is on this point: the Committee on Public Policy wanted to provide that when a change is to be made in the law at any future time, they be given the power to wipe off the statute books a part of a law which now reads that no stockholder or instructor in a medical school shall be a member of the Board of Medical Examiners.

The Reference Committee disagrees with the Committee on Public Policy and wants the law to stand just as it is.

Those who vote "aye", Mr. Speaker, supporting the Reference Committee, will vote to retain the law exactly as it is.

Speaker Seeger: Since there has been some question relative to the vote, I think it is entirely proper to ask that you vote again. Is it entirely clear to everyone now? Those who vote "aye" on this question are voting to retain a law which states that "no instructor, stockholder, member of or person financially interested in any school, college, or university having a medical department shall not be eligible for appointment to the Board of Medical Examiners.

And those who vote "no", vote that the law may be changed on the recommendation of our Committee on Public Policy.

Those in favor of retaining the law as it is, will please rise.

Secretary Crownhart: There are thirty-nine.

Speaker Seeger: Those who are in favor of authorizing the Committee to recommend a change in the law will please arise.

Secretary Crownhart: There are six, Mr. Speaker.

Speaker Seeger: The report of this Committee as it is finally voted on by you, will be voted on with this paragraph #7 (f) deleted.

Chairman Gundersen: In regard to the report of the Committee on Public Policy as a whole, the Committee recommends the adoption of the Committee's report, with the two reservations. I move the adoption of the report as amended by the House.

. . . The motion was seconded by Delegate A. A. Pleyte of Milwaukee, there was no discussion, and the motion was carried . . .

REPORTS OF OFFICERS

Secretary Crownhart: Mr. Speaker, I now have the report of the Committee on Reports of Officers, Dr. T. J. O'Leary, Chairman. I will read the report:

> "The Committee on Reports of Officers favorably submits the suggestion of President-Elect Jackson that our Society promote a voluntary Bureau of Correlated Health Activities—composed of the permanent secretaries, the active and past presidents, and the councilors of all the existing present agencies, a forum at which many perplexing questions could be presented and intelligently solved to the mutual advantage of society and organized medicine. Unless organized medicine occupies a central position and serves as a socially sympathetic guiding influence in moulding the pattern of things medical, the medical profession of this state will inevitably become steadily more subservient to lay supervision under political domination."

Dr. O'Leary, as Chairman of the Committee, moves acceptance of the first paragraph.

. . . The motion was seconded by Delegate J. F. Mauermann of Monroe. There was no discussion, and the motion was carried . . .

Secretary Crownhart: No. 2. The Report of the Chairman of the Council. We find this report to be a very comprehensive statement which has been published in the JOURNAL and we commend it to the members of the State Society for their careful perusal. The Committee feels that the members of the Council are entitled to great commendation for their splendid work.

Dr. O'Leary, as chairman, moves the adoption of that section.

. . . The motion was seconded by Alternate Delegate F. E. Butler of Menomonie. There was no discussion and the motion was carried . . .

Secretary Crownhart: The Report of the Treasurer. The Committee is amazed and gratified that the balance sheet of the State Society shows such a favorable condition in the present period. Dr. O'Leary, as chairman, wishes to move the acceptance of this report.

. . . The motion was seconded by Delegate Gunnar Gundersen of La Crosse, there was no discussion, and the motion was carried . . .

Secretary Crownhart: The report of the Secretary. This report meets with the approval of the Committee and takes this occasion to commend most highly the work of the Secretary and his co-workers. Dr. O'Leary, as chairman of the Committee, moves acceptance of this portion of the report.

. . . The motion was seconded by Delegate C. F. Peterson of Independence . . .

Secretary Crownhart: Mr. Speaker: One year ago the members of the House did not appreciate that in passing on this portion they were passing on the report of the Secretary as a whole, and we subsequently reopened this section that there might be discussion, and particularly criticism of the report of the Secretary.

I call this to your attention, Mr. Speaker, that if anyone wishes to discuss it, they have the opportunity. (The Secretary retired from the meeting room.)

Speaker Seeger: Gentlemen, you understand what it is you are voting on. This is a report of the Committee on the Reports of Officers, and you have approved three paragraphs. The fourth paragraph upon which you are now to vote refers to the report of Mr. Crownhart, the Executive Secretary, which was made here last night. It has been moved that that portion of the report of the Committee on Reports of Officers, be adopted. Dr. Peterson has seconded the motion, and it is before you for discussion.

Does anyone wish to discuss Mr. Crownhart's report? Your approval of this report of the Committee on Reports of Officers will indicate your approval of Mr. Crownhart's report, and of his recommendations.

. . . Question was called . . .

Speaker Seeger: Those in favor of adopting this paragraph of the report of the Committee on Reports of Officers will signify by saying "aye"; those opposed "no". The motion is carried. (The Secretary was called back to the meeting).

Secretary Crownhart: Mr. Speaker, before we conclude, may we have a motion to accept the report of the Committee as a whole.

Speaker Seeger: You have approved the various paragraphs, and in accordance with the rules of order, it is necessary that we have a motion to accept the report of the Committee on Reports of Officers as a whole.

Delegate D. E. W. Wenstrand (Milwaukee): I so move, Mr. Speaker.

. . . The motion was seconded by Delegate B. Krueger of Cudahy. There was no discussion and the motion was carried . . .

COMMITTEE ON RESOLUTIONS

Speaker Seeger: The next is the report of the Committee on Resolutions, which will deal to a large extent with the report of the Special Committees of the House. I believe they had better be discussed while we are in executive session, which mans that members of the State Society may remain, but that non-members must be asked to leave.

I will entertain a motion that this House go into executive session to receive the report of this Committee.

Delegate F. X. Pomainville (Wisconsin Rapids): Mr. Speaker: I move that the House of Delegates go into executive session.

. . . The motion was seconded by Delegate Gunnar Gundersen of La Crosse. There was no discussion and the motion was carried . . .

Secretary Crownhart: Mr. Speaker, may we have a recess for one moment. Is Mr. Wiprud in the room? Mr. Wiprud, will you act as sergeant-at-arms, please.

. . . Recess for one moment . . .

Speaker Seeger: The House will come to order, and I will call on Dr. Carter, of Green Bay, the Chairman of the Committee on Resolutions.

Chairman R. M. Carter: Mr. Speaker and Members of the House of Delegates: The Resolutions Committee this year has been faced with considerable business of extreme importance. Many of these questions are impossible of solution with the limited time at our disposal. So far as it could be done, we have endeavored to take a definite stand; where this was not possible, and where it was clearly apparent that further study was indicated we have referred the resolutions back to the proper committees for further study and later report. We trust that such action will meet with the approval of the House of Delegates.

WISCONSIN GENERAL HOSPITAL

Regarding the report of the special committee to investigate any and all procedures of admittances to the State of Wisconsin General Hospital, etc., this Committee has thoroughly discussed this report, and has also considered the additional information and recommendations submitted by Dr. R. H. Jackson, Chairman, and Mr. Crownhart. As a result, the Committee on Resolutions unanimously recommends the adoption of this special report, and recommends that the Committee be continued, with power to proceed as they see fit to bring about the necessary changes. The Committee on Resolutions also wishes to commend most highly the special committee for their thorough and painstaking work and for their fair and impartial report.

Mr. Speaker, I move that this report be adopted.

. . . The motion was seconded by Delegate C. D. Boyd of Kaukauna . . .

Speaker Seeger: The question before you is the adoption of the report of the Special Committee to Investigate Any and All Procedures of Admittance of Patients to the State of Wisconsin General Hospital.

This is the time for you to discuss this report, and the Committee on Resolutions recommends its adoption, as submitted to you by the Chairman, Dr. Jackson.

The procedure is that you may adopt it, as recommended. You may suggest amendments to this report, which amendments will be voted on before the question of the adoption of the general report—should any amendments be proposed. The question is now open for general discussion.

Delegate C. D. Boyd (Kaukauna): Mr. Speaker:

I am wondering whether this passing of this motion will permit the Committee members to formulate legislation for this coming session?

Chairman Carter: The recommendation is that the Committee be continued with power to proceed as they see fit to bring about these changes.

. . . Question was called . . .

Chairman Carter: I wish to say that the Committee endeavored to get in touch with Dr. Bardeen this morning, and were unsuccessful. If he is in the house and wishes to discuss the question we will be very glad to hear from him.

Speaker Seeger: If Dr. Bardeen wishes to say anything on this question I will be very glad to have him do so.

Dr. C. R. Bardeen: Mr. Speaker: I thank you for the invitation, but I think I would prefer not to discuss the report at this time. The Committee, as I understand it, has taken the matter up with the Board of Regents. Of course I shall be glad to carry out their instructions to the best of my ability.

. . . Question called . . .

Speaker Seeger: Is there any further discussion?

Delegate C. F. Peterson (Independence): Mr. Speaker: It seems to me that this question is of such grave importance that it is conferring considerable authority on four or five men to do as they please about the matter, without referring it back to the House of Delegates. My idea would be that we continue the Committee and that they report at the next meeting before any final action is taken, or before they commit this Society to any final action.

I do not doubt the feelings of the Committee, but I have my own idea about them. There may be a considerable feeling of enmity, for I think we have represented two factions of Madison, and if it should be a case of fighting each other, they may take some action that the majority of the House of Delegates will not approve. This is just an idea. It may not be true, but, just the same, I think the Committee should not be given the power to go ahead and do as they please.

I think they should be continued, and report back to the House of Delegates at the next meeting.

Speaker Seeger: Dr. Carter, as I understand it, the Committee requests authority to carry out the recommendations which they are asking to have approved. Is that correct?

Chairman Carter: The understanding, I think, of myself and the Committee was, the Committee would merely be continued to go on with their investigations. I do not think they can take any definite action without the approval of the House of Delegates. That is my understanding.

Delegate C. D. Boyd (Kaukauna): With these statements it might be well to put this off until next year. It delays legislation for at least three years. If there is any reluctancy in giving it to the three or four or five men on the Committee, the alternative would be to have that Committee guarded by the Council. Undoubtedly it would be easier for the Committee and the Council to meet together than to call a meeting of the Delegates.

Delegate D. J. Twohig (Fond du Lac): I have been watching the work of this Committee more or less ever since they began, and I believe that the Committee is made up of a very representative body of men of our state medical organization.

I think they have given this very careful study and a great deal of thought. I think it is not only for the betterment of the State Society, but I think it is for the betterment of the medical schools of the state that we uphold them in the proposition they put up to us.

I believe, at least I feel, that we ought to uphold this Committee in the resolution they are presenting. (Applause)

Speaker Seeger: I should like, for your information, and with Dr. Carter's permission, to read the paragraph which apparently is raising some question in your minds. The Committee's recommendation is as follows: "Your Committee suggests that the present Committee be continued for the purpose of doing that which seems proper to carry into effect such of the recommendations as may be adopted by your House."

Delegate H. T. Barnes (Delafield): Mr. Speaker: That Committee was appointed very wisely, I believe, from representative men from all over the state. That Committee does not represent a group of men in Madison, but it represents the State Medical Society from all over the state—representative men. I believe they are men we can trust with this, and believe that we should adopt this as the Committee has recommended. (Applause)

Alternate Delegate R. B. Rogers (Neenah): Mr. Speaker: We have been discussing this proposition for about three years, receiving letters and everything of that sort, and we want to know how this situation is going to be settled.

At the next meeting of our Society I would like to report the outcome of this situation.

I am desirous to know exactly where we stand. If we have been making tentative plans with regard to this proposition for two years, we should arrive at a decision now. We do not know anything about it up to date. In my estimation the proposition is that if we hospitalize a patient in our own hospital locally, we give our services, and the hospital gets $2.50 a day for the care of the patient.

I would like to see the proposition thoroughly discussed.

Secretary Crownhart: Mr. Speaker, if you adopt this section of the report of the Committee on Resolutions, and I want Dr. Jackson to correct me if I am in error as I go along, you will first, continue this Special Committee, and secondly, you will empower it to work out, as best it may, the following propositions:

(1) That with reference to the public patient now paid for jointly by the state and county, the Committee is going to endeavor to provide that the

state aid be no longer extended and that each individual county will pay the full rate for the cost of sending each individual public patient to Madison that it desires to send.

(2) That there will be a formalization of the records as regards the part-pay patient, in accordance with the Committee's report, so as to eliminate, in the estimation of the Committee, any opportunity that may presently exist for permitting patients to enter the hospital as semi-indigents, in fact, when in fact they are not deserving of such consideration.

(3) And with respect to the private patients, you are authorizing the special committee of the hospital to proceed to the Board of Regents, on the proposition that the room and floor space now devoted to private patients in the State Hospital, be devoted to the care of the indigent.

That either in the future the hospital place on full-time basis, and in particular they have reference to some few men who are doing a very small private practice, those men who are doing a private practice, or, that their private practice be so definitely outlined as for them to know their hours, and that such privilege at practice be carried on in any other institution, but that there be no patients of a private nature in the State Hospital. (Applause)

Speaker Seeger: Is the proposition perfectly clear?

Secretary Crownhart: Does that answer Dr. Rogers' question?

Alternate Delegate Rogers (Neenah): Yes.

Delegate Christofferson (Colby): Do I understand all of this will be acted upon by the Board of Regents except the state share of paying the hospitalization?

Secretary Crownhart: That is correct.

Alternate Delegate Rogers (Neenah): Mr. Speaker, we are willing to give our services in Winnebago County with no charge to the patient. We want to hospitalize our patients in the hospital in our county but we do not want to give the $2.50 to be distributed through Dane County. We prefer to distribute it to the grocery stores in Winnebago.

Secretary Crownhart: Mr. Speaker, if I may answer that question for the Committee—if you authorize and adopt this report you are authorizing your State Committee to seek to wipe out state aid —each county will pay for its own patient.

Dr. A. H. Heidner (West Bend, Councilor, Fifth District): Mr. Speaker: As I understand this proposition, we are authorizing this Committee to carry out, in the best way they can, these specific recommendations they have made.

The other question—the Committee is to be continued. Is that continuation to be for future study or are we authorizing them to continue and carry out other things that they find desirable during the year, without further authority? I think that is the crux of the whole argument.

Speaker Seeger: For Dr. Heidner's information and for those of you who do not understand, I will again read Par. 2 of the recommendations of the Committee which states: "Your Committee suggests that the present committee be continued for the purpose of doing that which seems proper to carry into effect such of the recommendations as may be adopted by your House."

Apparently, it has not in mind initiating any new activity without authority from the proper source.

. . . Question called . . .

Speaker Seeger: Is there any other discussion? (None) If not, are you ready for the question?

. . . Question called . . .

Speaker Seeger: The question before you is the adoption of the report of the Committee on Resolutions, which report recommends the adoption of the report of the Special Committee on the Wisconsin State Hospital, and approves of the recommendations of that Committee. Those in favor, signify by saying "aye". Those opposed "no".

. . . The motion was carried without dissent . . .

Speaker Seeger: It is so ordered.

Delegate Gunnar Gundersen (La Crosse, Regent, University of Wisconsin): May I have the floor? As a member of the Board of Regents of the University of Wisconsin, and chairman of the Medical Committee of the Board, I worked as an ex officio member on this Committee. I was anxious to serve on the Committee, but I have been in a peculiar position for the reason it will be necessary for me to sit as a judge, subsequently as a member of the Board of Regents on any recommendations which this Committee may make. For that reason I believe it has been a little inconsistent, and from now on, I wish to be relieved of service on that Committee.

Speaker Seeger: Dr. Gundersen's request will be referred to the President, who makes the appointment, as I understand it.

We will proceed with the report of the Committee on Resolutions.

PANEL PRACTICE

Chairman Carter: Regarding the progress report of the Special Committee on the Distribution of Medical Services, and the Supplemental Report on Contract and Panel Practice. As to the report in general, we recommend its adoption and the continuance of the Committee.

In view of the unsettled state of conditions in general, we feel that a fact-finding committee, such as this one, is indispensable for the future welfare of the medical profession.

In regard to recommendation number two, Contract of Panel Practice, page one of the Supplemental Report dealing with panels under the Workmen's Compensation Act, we feel that this is a matter of controversy and that further investigation is needed. Whether legislative action asking to allow free choice of physicians under the Workmen's Compensation Act is best, or whether conferences should be held between the interested parties with a view to enlarging existing panels is a question

which we are unable to determine in the limited time at our disposal. We therefore recommend that this question be referred back to the Special Committee for further consideration and later report. We also commend most highly the Special Committee for its excellent and untiring work.

I move the adoption of this report.

Speaker Seeger: The question before you, before we act upon the adoption of this report, is whether or not the following paragraph, which I shall read, shall be referred back to the Committee for further study. The paragraph which the Committee on Resolutions believes should be referred back is the following:

> "2. We concur in recommendation number three that it is to the mutual best interest of the injured that panels under the Workmen's Compensation Act include all physicians willing and capable of doing compensation insurance work. We suggest that the House of Delegates give the appropriate committee of the State Society specific instructions whether the foregoing objective best may be accomplished by supporting legislative measures providing 'free choice of physicians by the patients', or (2) whether it is to be accomplished by contacts with the insurance companies to the end that existing panels may be enlarged."

The Committee on Resolutions recommends that we adopt the report of these Special Committees on the Distribution of Medical Services, and on Contract and Panel Practice, but, that this paragraph be referred back to the Committee for further study, and the question before us is whether or not this paragraph shall be referred back for further study, or whether it shall be retained as it is in the report which you finally vote upon this evening.

I will entertain a motion relative to this matter to bring it before you.

Chairman Carter: Mr. Speaker: I move that Par. 2, as read by Speaker Seeger, be referred back to the Committee for further study.

. . . The motion was seconded by Delegate H. H. Christofferson of Colby . . .

Speaker Seeger: This question as before you is that this paragraph be not included in the report finally adopted, but this problem be specifically referred back to the Committee for further study. Is it clear in your mind? Is there any discussion?

Chairman Carter: Mr. Speaker: I might say in that connection, this looks a whole lot like passing the buck, but we discussed this question rather freely and there are a lot of arguments on both sides. We did not feel we were justified in taking a definite stand on merely one hour's or maybe an hour and a half's discussion. We felt a little more information was necessary.

Dr. Gilbert E. Seaman (Chairman Special Committee on the Distribution of Medical Services in Wisconsin): Mr. Speaker: This matter has been the subject of very considerable discussion, and I think there are one or two things that should be made perhaps more clear than the report makes them without very careful study.

In the first place, this report on Contract and Panel Practice is the result of a study made by the Medical Society of Milwaukee County, and this study was made in cooperation with the Committee of the State Society, and was paid for from the funds of the State Society.

It seems to me that the situation, therefore, is this: that it may be that the Medical Society of Milwaukee County will adopt this report as their action, including the paragraph referred to.

And if they do, the question is whether they may determine to go to the legislature through their Committee on Legislation and ask for the necessary legislation. I would therefore like to hear some discussion along that particular line, as to whether this shall be a matter of law, as to a free choice of physicians, or a matter of conference with those industries concerned, and those insurance companies concerned, as Dr. Carter says is in the minds of many an open question.

Our Committee, therefore, asks this Society for discussion, for advice, for interest. This is an important question. The motion of the chairman of the Committee on Resolutions is that it be referred back for further report.

There is a legislative meeting or session next winter. The question is, when that further report shall be made and to whom, and shall we look forward perhaps to some concrete suggestions in the way of legislation at the next winter session?

I would suggest it be made clear in the discussion by the officers of the Society, whether this further report on this particular paragraph be made to the officers of the Society, to the House of Delegates, to the Council, or whether no report upon it is expected until the next annual meeting of the Society. If that is in the minds of the members, then, of course, there could be no proposed legislation, with the authority, and with the support officially of the State Society as an organization until the next meeting of the Society. So it would preclude action at the next session of the legislature.

I would like to hear this particular paragraph discussed.

Dr. John McGovern (Milwaukee): There is not one iota of definite understanding in either the State or Panel System reports. I agree heartily with Dr. Seaman in his report. It is a beautiful report, but it has not one iota of definite report in it, and Dr. Seaman says he doesn't intend to make any definite recommendation.

I want to ask the Committee of the Milwaukee County Medical Society: Are you folks going to make any definite report?

At a meeting of the Milwaukee County Medical Society, before that Committee was appointed, the President of the Society came out very strongly in favor of finding out facts. We cannot do anything without facts. I cannot see a fact that has been brought out that amounts to a hill of beans.

Everybody understands the panel system. Any medical man who doesn't understand the panel system has something wrong with him mentally—more than likely he is a coward, afraid to face a real situation.

Have the medical men enough spirit, have they enough backbone to run their own business? Or are you going to allow manufacturers to practice medicine in this state indefinitely?

Are you going to allow lodges to appoint a panel of physicians to take care of hundreds of sick people—make a bluff at taking care of them? That is the situation.

I have put in definite recommendations, definite amendments to the Industrial Commission Law, and I do not hear a man say a word about these definite recommendations that I made. I will say right here, if nobody else puts these into the legislature, I will do it alone. I put stuff across before, and I can do it again. (Applause)

I would like to hear from the Milwaukee County Medical Society. I am willing all the time to cooperate, but what will the Milwaukee County Medical Society do? Dr. Gramling, who has been on their Committee told me yesterday "I heartily agree with you in everything."

Have these fellows enough backbone to stand up and agree and recommend something worth while?

Speaker Seeger: For the information of Dr. McGovern and the House, I will ask Mr. Crownhart to read a paragraph of the Committee report referring to the issue he has raised.

Secretary Crownhart: On page 14, paragraph 3.

> "The Committee believes that in the best interests of the public and the medical profession the medical panels set up under the provisions of the Workmen's Compensation Act be enlarged to include all physicians willing and capable of doing compensation insurance work, and recommends that every effort be put forth by the Society to attain this objective."

The only question, Mr. Speaker, is whether this effort shall be one through contact with the insurance companies, or through supporting legislation to provide free choice by the patient as a matter of law.

Dr. Seaman: Mr. Speaker: That is just the question. In order to be definite: this Committee, if it is to continue the work, wants to know whether it is expected that we shall make a definite effort at legislation, or whether we shall institute a definite effort along the line of conference with the industry and insurance companies. What does the State Society want? And when that has been determined, and when the Committee has given its further report, do they wish us to defer our further report to the next annual meeting of the Society, or do they wish us to proceed before the next annual meeting of the Society?

Dr. McGovern: I wish to speak—

Speaker Seeger: Before you speak may I say one word, Dr. McGovern? I interpret it as the duty of the Speaker to facilitate the business of this House, and in commenting on the recommendation of the Resolutions Committee, I have this to say: this paragraph which is under discussion, contains really two separate points. One is that the Committee (Dr. Seaman's Committee) concurs in the recommendation that it is to the best interests of the injured that panels under the Workmen's Compensation Act include all physicians willing and capable of doing insurance work.

I think that in itself is a very definite point. The Committee then suggests, in order that it be informed as to the best method of procedure and in order to get the benefit of your advice, that discussion be carried on here relative to whether or not this objective may best be accomplished by supporting legislative measures, etc.

I would suggest that it might facilitate matters to divide this paragraph and consider the two sections separately.

Chairman Carter: That is what we have done in this resolution:

> "In regard to recommendation number two, Contract and Panel Practice, page one of the supplemental report dealing with panels under the Workmen's Compensation Act, we feel that this is a matter of controversy and that further investigation is needed. Whether legislative action asking to allow free choice of physicians under the Workmen's Compensation Act is best, or whether conferences should be held between the interested parties with a view to enlarging existing panels is a question which we are unable to determine in the limited time at our disposal. We therefore recommend that this question be referred back to the special committee and further consideration and later report."

President Otho A. Fiedler: It strikes me we cannot decide now and here which of these two methods is the better to pursue. I think there have already been some conferences between insurance carriers and industrialists, and the Committee, with a view to settling this matter between them to keep it out of the legislature.

At the discretion of the Committee it would seem to me that if this should fail, you have only one other resource—that is, to present it to the legislature. I think it is much better to accomplish our purpose by conference, and by agreement, than by going to the legislature. You do not know where you are going to end or how deep you are going when you go to the legislature. Why not leave it to the discretion of this Committee to make efforts to compromise. If they cannot, they have the authority to proceed with the legislative program.

Dr. McGovern: I think the President will agree with me after the chairman of the Committee read his report that there was nothing definite recommended.

Suppose we discuss it from the standpoint of the

panel system report—that the panels be enlarged. What does that mean? It means that either the manufacturer or the insurance company is going to practice medicine.

Contrary to the laws of the State of Wisconsin we recognize him as a man practicing medicine.

I don't know how many of the men here have been on a panel. Dr. Gramling told me that he has been on a panel and I have had the same experience. Just as soon as you are put on a panel—I don't care how big it is—the insurance company or the manufacturer is the boss, and when you have a case where you believe that the injured man should receive fair compensation, you will be given to understand that you are to testify in a certain way, and if you don't testify in that particular way, you are never called again to testify in their cases before the Industrial Commission.

That is the experience of every man. With all the manufacturing in Milwaukee, a few men have been doing all of the work. Special work would be recommended to specialists all over the town, just for a special case, and that man would be allowed to charge as he pleased and do as he pleased, and they pay him a good fee.

A physician who treated a patient and who knew his disabilities could not do his honest duty to that patient when the manufacturer and insurance company were concerned. It cannot be done and it has not been done, and it has been growing gradually worse and worse.

Here is another thing: a doctor in one of the big plants in this town was on the panel. I talked to him and I verified the story I am going to tell you—he asked me not to use his name. He was called to the plant to see an individual who had a fracture of one or more bones in his foot.

The doctor dressed the foot. He was told then by the foreman in the shop that he was through with that case, that the plant nurse would take care of it.

He said, "Not on your life. I do not dress that foot and turn it over to a nurse and then be responsible for malpractice afterwards." He has not received another case from that plant, and never will.

Now there is the situation. Are we going to allow the insurance company and the manufacturer, who are financially interested, to lower their premiums, and to increase their dividends,—to practice medicine and let them get away with it?

Delegate H. J. Gramling (Milwaukee): Mr. Speaker, and Members of the House of Delegates: I admire Dr. McGovern's enthusiasm, and I agree with him in many things, only I differ with him in the approach. The question, I am speaking not as a member of the Board of Directors, but for myself, has come to this: I have practiced medicine in Milwaukee for thirty-three years, and, gentlemen, in another two years I will have to move out into a small town and practice with the rest of you up in the state.

That is the situation here, and Dr. McGovern is right in so far that the encroachment of contract practice, unless you do it yourself, is so great you are out. And the condition in Milwaukee is really acute.

I believe that I am speaking the sentiments of the rank and file of the younger men in the city of Milwaukee. They feel conditions in the city of Milwaukee at present are absolutely intolerable.

Ladies and gentlemen, here you have the finest medical schools in the country. You are turning out the best men in the world. You have the best hospitals here in this country. You have wonderful staffs, and yet you are willing to put your neck under the industrialist's yoke, and do what they tell you, and they dictate to you.

I, for one, won't do it. But there are young men who are unable to be as independent as those of us who have practiced longer.

I believe that the House of Delegates would feel kindly if the Milwaukee Medical Society should take a definite stand, which probably it is not ready to do, but some day in the future it will take a definite stand. Do you gentlemen feel that the Milwaukee County Society is encroaching on your jurisdiction? Personally, I believe, if you gentlemen feel we are not trying to usurp your authority, Milwaukee County may do something. That is as far as anybody can go at the present time, but if some decision is reached in Milwaukee, I hope the State will not take offense at it if we do act. (Applause)

Speaker Seeger: The Committee, as I understand it, from discussing this with Dr. Carter, is in accord with the agreement that the panels under the Workmen's Compensation Act include all physicians willing and capable of doing compensation insurance work. The Committee does not feel, however—you will please correct me Dr. Carter—that this Special Committee should be instructed by the House at this time definitely as to the course to pursue to accomplish this object, and that is the reason for referring this back to the Committee. Is that correct, Dr. Carter?

Chairman Carter: Yes.

Question: What was that last statement?

Chairman Carter: The Committee felt that this question as to whether it should be solved by legislative action or conference with insurance carriers, was altogether too big to be settled in the limited time at our disposal.

Consequently, we felt it better to refer it back to the Committee for further study. We expected no action by the House of Delegates tonight.

Dr. McGovern: Mr. Speaker: May I make a motion?

Speaker Seeger: There is a motion before the House.

Dr. McGovern: May I amend that motion?

Speaker Seeger: You may. I will state the motion before the House in order to make it perfectly clear. The motion before the House is that Par. 2 of this report, which we have read, be referred back

to the Committee, and be omitted from the report as it is finally adopted.

Dr. McGovern: My amendment is that the Committee be instructed to formulate a definite plan for the correction of the abuses that exist in the panel system and in industrial medicine, and introduce into the next legislature, if they think it is necessary, bills to correct the abuses.

Speaker Seeger: Do I hear a second?

. . . The motion was seconded by Delegate H. M. Lynch of West Bend . . .

Speaker Seeger: The motion is that this paragraph be amended, when it is referred back, in this form: that the Committee is instructed to formulate plans to correct the abuses which exist under the panel system and to formulate legislation which may be introduced at the next legislative session if it is deemed necessary in order to correct these abuses. Is that the sense of your motion, Dr. McGovern?

Dr. McGovern: Yes.

Speaker Seeger: Is there any discussion on this amendment?

Delegate H. J. Gramling (Milwaukee): Mr. Speaker: There again I disagree with Dr. McGovern. I think before this question goes to the legislature you have to settle among yourselves what you want to do. You cannot go to the legislature with a divided Society. You have to have a unanimous front if you want to go. First settle the difficulty absolutely in your own county, and when you are all united, then come back and go to the legislature and correct the wrongs as you see them, if you can do it.

I believe if you go before the legislature with a divided Society you would absolutely get nowhere, and in the end we will suffer, because we will be unable to put our program over.

Dr. Gilbert E. Seaman (Chairman Special Committee on Distribution of Medical Services in Wisconsin): Mr. Speaker: Our Committee wants to hear a full discussion of any question involved in this report, if the Committee is to be continued, and particularly on this question.

It is a pretty large order for our Committee, which is frankly a fact-finding Committee, to determine the abuses in the Contract and Panel Practice System, and to suggest the remedy before the legislature at its next session, without referring it back to the State Medical Society, and without specific instructions, if we are going to represent the State Medical Society.

Furthermore, the State Medical Society has a Committee on Legislation. The county medical society of most counties, or a good many counties, certainly in Milwaukee County, has a committee on legislation. Unquestionably, the Medical Society of Milwaukee County will make this report, including this paragraph, their final action on this question.

But our discussion relates to the position of the State Society. It is altogether likely there are some men here who do not know that this question of the free choice of physicians was debated and discussed, and a bill was introduced in the last session of the legislature.

The State Society has never taken a definite stand on that question. This bill for the free choice of physicians was not passed. It was beaten by the insurance companies because they convinced the Committee of the Legislature that under the system of free choice of physicians there would be a lot of bad medical work done. That is why they "beat the bill."

Sometime, somewhere, the State Medical Society should take a position upon this question: Shall it be the free choice of physician as a matter of law in the end, or shall this matter be handled by conference with insurance companies, and with employers?

That is a definite proposition, isn't it?

And this Committee (I am sure I speak for the other members of the Committee) does not wish to make up the mind of the State Medical Society without instructions, and does not propose to do it.

If we believe (as I believe) in the right system of the free choice of physicians, and in the medical profession running their own business—we should take a stand on it sometime. If we believe that the interests will best be served by conference and perhaps a more conservative stand, or, if we believe that in one part of the state it shall be left to the county society to determine for themselves what they shall do, so far as they are concerned, and in another part of the state some other method shall be pursued, let's say that. But we want definite discussion.

Dr. McGovern: Mr. Speaker: I want to correct Dr. Seaman's statement regarding the bill introduced in the last legislature. It passed the assembly; it was killed in the senate by the most vicious log-rolling that any bill ever faced, and not one iota of support from the medical profession. The Committee on Medical Legislation of the State Society ignored it entirely, never appeared to help it, and the assembly passed it but it was killed by amendments in the senate.

I would suggest an addition to my amendment,—to have the Council finally pass on the decision of the Committee. I am willing to compromise, but I want something done, and if you don't do it, I will do it myself.

President Otho A. Fiedler: That leads me to say something I have been wanting to say; namely, that the legislative committee did not take action in this matter, nor do we propose ever to take action in legislation, until we have instructions from the House of Delegates as to what we are to do. (Applause)

We are not acting for ourselves, we are acting for the State Society in our legislative matters, and this seems to be a mild indictment of the legislative committee. I resent it, inasmuch as we had no instructions from this House of Delegates as to what your desires were in this matter. When once you have expressed your desires, and when you instruct

the legislative committee what it is to do, the legislative committee will exert every effort to bring about the results that you desire.

Nor do we think that we individually, nor any other member of this Society has a right to go before the legislature and assume that he represents the Medical Society of this state, and ask for legislation. (Applause) We think it would be wrong, and it would defeat every purpose we have. It would defeat the objective which we have built up of creating in the legislature an idea that we come before it only with measures of public interest.

If these matters become personal interests or the particular pet hobby of some one individual without the support of the whole medical profession,—it will become divided and the profession will lose its influence in legislation. (Applause)

Dr. McGovern: In the WISCONSIN MEDICAL JOURNAL of just a few months ago, Dr. Fiedler appeared in favor of the panel practice. Apparently, he does not know what the panel system is in Milwaukee. With the panel system in Sheboygan, he can make his own charge for cases referred to him. It does not compare with Milwaukee, with a nurse and the manufacturer and the insurance company taking care of the whole works.

If you see a man being killed in the street, don't interfere, don't care whether it is right or wrong, or what happens,—don't interfere. Just let the stuff go on.

Dr. Gilbert Seaman (Chairman Special Committee on Distribution of Medical Services in Wisconsin): Mr. Speaker: I wish to call attention to one sentence of this progress report of this Special Committee—it constitutes our creed, "The medical profession has no vested rights which are incompatible with public well-being."

If we do not stand on that proposition, and if we put this thing on a personal plane, on a matter of the interests of men personally, and if we serve any special interests anywhere, whether it relates to public health, whether it relates to the University, whether it relates to contract medicine—if we take any position which contravenes the public interest, we are not in the position that we should occupy, and we will be defeated, and we will deserve to be defeated.

Gentlemen, the State Medical Society must say what the State Medical Society shall propose, and what its Committees shall propose. (Applause) And speaking as one member of the Committee, I will say that I will make no proposals to the legislature purporting to represent the State Medical Society of Wisconsin, unless the State Medical Society of Wisconsin, in advance, gives us the authority, and gives us the instructions to do so. (Applause)

Dr. Spencer D. Beebe (Councilor, Seventh District): I am interested in that Milwaukee Medical Society. After Dr. Gramling got up and made that pathetic speech, I know that Monroe County has something too. Fellows, come up and we will colonize you on our cranberry and huckleberry marshes. But if you come to the city of Sparta, we are going to call out the fire and hose department. (Laughter)

Speaker Seeger: The question is on Dr. McGovern's proposed amendment that this recommendation No. 2, be amended with a specific instruction which calls upon the Committee to formulate a plan to overcome the abuses of the Panel System, and to formulate legislation which should be introduced if it is necessary at the next session of the legislature. You are voting on the question whether or not the Committee shall be so instructed. Are you ready for the question?

Delegate C. F. Peterson (Independence): Mr. Speaker: I would like to ask a question. We have a Committee on Legislation now. If we instruct the Special Committee to go before the legislature and secure this legislation are we not scattering our forces?

It seems to me we should either delegate this work to our regular legislative committee, or discharge that committee.

Secretary Crownhart: Mr. Speaker: Perhaps I can clear up Dr. Peterson's point. The Committee's report said, "instruct the proper committee of the Society," and I interpret Dr. McGovern's amendment to mean that he is instructing the Committee on Public Policy, which is the committee on legislation.

Speaker Seeger: Are you ready for the question?

. . . Question called . . .

Speaker Seeger: The question is on the instruction of this Committee as was stated. Those in favor please signify by saying "aye"; those opposed, "no".

. . . The vote was indecisive . . .

Speaker Seeger: I will call for a division of the House. Those in favor will stand, please.

. . . Speaker Seeger stated the question again . . .

Delegate G. R. Duer (Marinette): As I understand the amendment that was made, it was not only to instruct this Committee to prepare those recommendations, but it was to give them authority to present them to the legislature at the next session.

Speaker Seeger: Yes, if it was thought necessary.

Delegate Duer: I am opposed to any such amendment for the reason that the House should express its wish on that matter before it takes those recommendations before the legislature, as was expressed by our President a few moments ago.

Speaker Seeger: Those in favor of so instructing the Committee will please rise.

Secretary Crownhart: Mr. Speaker, there are five.

Speaker Seeger: Those opposed will please rise.

. . . The majority rose . . .

Speaker Seeger: The amendment is lost. The question now before us is the question put by Dr. Carter that this recommendation No. 2 be referred back to the Committee before the report is adopted. Are you ready for that question?

. . . Question called . . .

Speaker Seeger: Those in favor of referring back this recommendation No. 2 will signify by saying "aye"; those opposed "no".

. . . There was no dissent and the motion was carried unanimously.

Speaker Seeger: As I understand it, we are now ready to pass upon the recommendation of the Resolutions Committee that this report, with Par. No. 2 referred back to the Committee, be adopted.

Is there any discussion on the adoption of this general report? Has anyone any amendments to suggest to this report?

Delegate J. W. Prentice (Ashland): Mr. Speaker: This investigation has been entirely in Milwaukee County, and the situation as it exists here is greatly different than it is in Ashland or other parts of the state.

I would suggest that after this Special Committee formulates its new instructions that they be referred to the individual county societies throughout the state for their action. The county societies should advise their Councilor of their action so that the Councilors in meeting may determine with the Committee as to what is to be done.

Speaker Seeger: This is made as a suggestion to the Committee. I do not believe it needs a motion, unless there is some further discussion. You make this as a suggestion?

Delegate Prentice: I make it as a motion.

Speaker Seeger: I doubt very much if that motion is in order at this time.

The question before us is the adoption of the report of the Reference Committee, which is that we adopt this report, with the deletion of the paragraph referred back to them. If you wish to make an amendment, you may.

Delegate Prentice: May I withdraw it, and put it in after we vote on this?

Speaker Seeger: You may, yes. It has been moved and seconded that the report of the Resolutions Committee endorsing the report of the Special Committee on Distribution of Medical Services in Wisconsin, with Par. 2 of the recommendations referred back to the Committee, be adopted. Those in favor please signify by saying "aye"; those opposed "no". The motion is carried.

Dr. Prentice, your motion is now in order.

Delegate Prentice: I move that after this Committee formulates its further findings and suggestions and recommendations, that such recommendations be sent to the individual county societies, and that they be acted upon by the county societies, and their action be brought to their Councilor, so that the Council may discuss it and make recommendations to the Committee.

If that could be done before the next legislature meets, this Committee would then have definite ideas as to what the desires are throughout the entire state.

Secretary Crownhart: As I understand Dr. Prentice's motion, Mr. Speaker, it provides that the Committee on Distribution of Medical Services shall make further findings of fact, which findings, with their recommendations, shall be reported to the county medical societies, which societies shall act at once, either expressing favor or disfavor of the findings or recommendations of the Committee. Further, these findings of the county societies shall be made known to the Councilors, and that the Council shall have authority to determine the position of the Society before the legislature at the coming January meeting of the Council.

Speaker Seeger: The Chair would like to know whether this motion in any way conflicts with the original motion. (No)

. . . The motion was seconded by Alternate Delegate F. E. Butler of Menomonie . . .

Speaker Seeger: Is there any discussion? (None) If not, those in favor signify by saying "aye"; those opposed "no". The motion is carried.

Dr. Carter will continue with his report.

OTHER RESOLUTIONS

Chairman Carter: Regarding the resolution of Dr. McGovern, having to do with changes in the law governing the Industrial Commission, we recommend that this be referred to the Committee on Public Policy and Legislation.

. . . The motion was seconded by Alternate Delegate Oscar Lotz of Milwaukee. There was no discussion, and the motion was carried . . .

Chairman Carter: Regarding the resolution of Dr. McGovern concerning patent medicines. Appreciating the tremendous economic loss sustained by the public in the ill-advised purchase of patent medicine, we doubt whether a solution can be arrived at by state legislation; we feel this is a matter for federal legislation. We accordingly suggest that this subject matter be referred to the Committee on Public Policy and Legislation.

. . . The motion was seconded by Delegate C. F. Peterson of Independence. There was no discussion and the motion was carried . . .

Chairman Carter: Regarding the resolution of Dr. McGovern dealing with reorganization of the Council, the Committee on Resolutions recommends the present tabling of this resolution.

. . . The motion was seconded by Delegate H. T. Barnes of Delafield . . .

Speaker Seeger: This subject is open for discussion.

Question: What is the resolution?

Chairman Carter: The Secretary will read it.

Secretary Crownhart: The resolution reads as follows:

> "I wish to call the attention of the House of Delegates to the great difference in membership in the State Society in the various council districts. The eighth district has thirty-nine members; the twelfth district has 638 members; the first district has 102 members; the third district has 311 members; the

fourth district has 76 members. In fairness to the different sections of the state, I think that the House of Delegates ought to reorganize the Council of the State Society and give each district as nearly as possible the same number of members in the State Society. Therefore, be it resolved, that the House of Delegates appoint a committee to reorganize the Council."

Speaker Seeger: The motion to table is not debatable. Those in favor please signify by saying "aye"; those opposed "no". The motion is carried.

Chairman Carter: Regarding the resolution of Dr. McGovern relative to the changing of the statute 147.185 to 147.18, the Committee recommends that this be referred to the Committee on Public Policy and Legislation. Also, regarding the resolutions of Dr. McGovern relating to the repeal of section 147.18, we recommend that this be referred to the Committee on Public Policy and Legislation.

Speaker Seeger: Is the House satisfied to act upon these two resolutions? They relate to the same thing.

Secretary Crownhart: They provide, in part, Mr. Speaker, for revoking so much of the Medical Practice Act as permits of licensing of itinerant practitioners. I assume the position of the Committee is based on the fact that this House of Delegates has already favored abolishing the itinerant practice of medicine, and has already introduced a bill for that purpose, which has been defeated once, by reason of opposition of the State Board of Medical Examiners.

. . . The motion made by Chairman Carter was seconded by Delegate C. F. Peterson of Independence. There was no further discussion, and the motion was carried . . .

Chairman Carter: Regarding the resolution of Dr. McGovern relating to the practice of medicine by any corporation, club, or any other association, we recommend that this be referred to the special committee of medical services for investigation and further recommendations.

. . . The motion was seconded by Delegate R. G. Arveson of Frederic. There was no discussion and the motion was carried . . .

Chairman Carter: Regarding the resolution of Dr. McGovern relating to appointment of medical examiners, we recommend that this be referred to the Committee on Public Policy and Legislation.

. . . The motion was seconded by Alternate Delegate Oscar Lotz of Milwaukee . . .

. . . Question called . . .

. . . There was no discussion and the motion was carried . . .

Chairman Carter: The resolution of Dr. McGovern relating to religious healers. The Committee recommends the tabling of this resolution. I move the adoption of this report.

. . . The motion was seconded by Delegate L. W. Peterson of Sun Prairie. There was no discussion and the motion was carried . . .

Chairman Carter: Regarding the resolution of Dr. McGovern referring to automobile drivers. The Committee approves the sentiment and moves it be referred to the Committee on Legislation.

. . . The motion was seconded by Delegate H. J. Gramling. There was no discussion and the motion was carried . . .

Chairman Carter: Regarding the recommendations of our retiring President, Dr. Otho A. Fiedler, we recommend their adoption. As to the setting up of an expense account for the President, we feel that this would be highly desirable and it is especially recommended to the Council for its consideration and attention.

. . . The motion was seconded by Delegate R. G. Arveson of Frederic . . .

Speaker Seeger: This matter is now open to you for discussion.

. . . Question was called. There was no discussion and the motion was carried . . .

Chairman Carter: Regarding the resolution introduced by Dr. P. A. Fox, we recommend that this be referred to the Special Committee on the Distribution of Medical Services in Wisconsin, for their further consideration and future recommendations.

. . . The gist of this resolution was given by Secretary Crownhart . . .

. . . The motion was seconded by Delegate J. W. Prentice of Ashland. There was no discussion and the motion was carried . . .

Chairman Carter: The Committee recommends that the dues for 1933 remain at $15.00 per year, as at present. We recognize the fact that we are passing through a period of marked depression. On the other hand, if there ever was a time when the state organization should function at its highest efficiency, now is that time. To ask any substantial reduction in dues would mean drastic cuts in the entire budget, with consequent crippling of the entire organization, therefore, we feel that the dues should remain as they are. I move the adoption of this report.

. . . The motion was seconded by Delegate H. H. Christofferson of Colby . . .

Speaker Seeger: The question is before you for discussion.

. . . Question was called. There was no discussion and the motion was unanimously carried . . .

Chairman Carter: Regarding the resolution introduced by Dr. John O. Dieterle of Milwaukee and reading as follows: "Amendment to Sec. 1, Ch. 8, of the By-Laws, dues and assessments, provide that when a member shall have paid his dues for thirty-five years he shall become a life member and he shall be exempt of further dues and a certificate of membership should be issued to such member unanimously."

The Committee on Resolutions has changed this to read as follows: "To provide that when a member shall have paid his dues for thirty-five years, upon request of his county medical society, he may become a life member and shall then be exempt

from the payment of further dues and a certificate of membership shall be issued to such member annually." We recommend the adoption of the resolution as amended.

. . . The motion was seconded by Delegate L. V. Littig of Madison . . .

Chairman Carter: I might say the reason for changing the wording was, that we felt occasions might arise when certain men might take advantage of that provision, as it was originally worded. The amended wording makes it necessary for the county society to request of the State Society the admission to life membership.

Speaker Seeger: Unless there is objection by Dr. Dieterle, I will call for a vote on the adoption of this resolution as amended by the Resolutions Committee.

Delegate J. O. Dieterle (Milwaukee): Mr. Speaker, I think the change suggested by Dr. Carter is a good one, and I accept the change.

. . . There was no discussion and the motion was unanimously carried . . .

BOARD OF HEALTH STUDY

Chairman Carter: The Resolutions Committee wishes to introduce a resolution of its own. I will ask Secretary Crownhart to read this resolution.

. . . Secretary Crownhart read a resolution introduced by Dr. George F. Adams, reading as follows:

> "WHEREAS, This Committee realizes and recognizes that the Wisconsin State Board of Health is working along 'Old Style' lines and that a reorganization could be made to the great advantage of all our citizens; and
>
> "WHEREAS, The Committee on Public Policy has recommended in their report that they 'under take a study of the model law governing the Board of Health of New York State,' a copy of which detailed report of the Special Committee appointed by Governor Franklin D. Roosevelt entitled 'Public Health in New York State' is affixed to this Resolution; and
>
> "WHEREAS, We of the state of Wisconsin, as medical practitioners, are desirous that our state have the benefit of the up-to-date methods so that our State Board of Health can be truly progressive; now, therefore be it
>
> "*Resolved*, That we approve the recommendation of the Committee on Public Policy and they are hereby directed to carry out their recommendation to fully and completely study the model law governing the Board of Health of New York State; and, be it further
>
> "*Resolved*, That this Resolution upon passage be referred to the Committee on Public Policy; said Committee to report at the next Convention assembled their recommendations for changes in the laws of the state of Wisconsin to carry into effect any recommendations said Committee might make after the examination and study of the New York State Board of Health Law."

Chairman Carter: The Committee on Resolutions recommends the adoption of this resolution.

. . . The motion was seconded by Delegate C. F. Peterson of Independence . . .

Speaker Seeger: The matter is open for your discussion. Dr. Adams, do you wish to discuss it?

Delegate G. F. Adams (Kenosha): No.

. . . There was no discussion and the motion was carried . . .

Chairman Carter: Mr. Speaker, I now move the adoption of this report as a whole.

. . . The motion was seconded by Delegate J. W. Prentice of Ashland and carried . . .

Speaker Seeger: I will now entertain a motion we rise from executive session.

Delegate F. A. Thompson (Milwaukee): Mr. Speaker, I so move.

. . . The motion was seconded by Alternate Delegate Oscar Lotz of Milwaukee, and carried . . .

Speaker Seeger: The Committee on Medical Defense offers an amendment to the By-Laws. This amendment having laid over for one day, it is now ready for action. I will ask the Secretary to read the amendment.

Secretary Crownhart:

> "Recommendation: Under the present by-laws of the Society a member is not entitled to medical defense if his dues are not paid by February 1st of each year. Inasmuch as the Society itself does not remove a member from the mailing list or consider him in arrears for all other purposes until March 31st, it is our recommendation that the By-Laws be amended to grant a like time extension for Medical Defense. The proposed amendment follows:
>
> "Amend Section 3, Chapter VIII, By-Laws of the State Medical Society of Wisconsin by striking out the words 'February 1st' where they occur therein and substitute therefore the words 'March 31st'."

Speaker Seeger: The By-Laws provide that the By-Laws may be amended at any annual session by a majority vote of the delegates present at that session, if the proposed amendment has been properly submitted to the House of Delegates and has laid on the table for one day.

. . . Those in favor of the proposed amendment will please signify by saying "aye"; those opposed "no". The motion is carried . . .

Speaker Seeger: Is there any new business to come up at this time?

Secretary Crownhart: Mr. Speaker, this clears the business on the desk of the Secretary.

I would like to announce, Mr. Speaker, that with the consent of the House the Secretary has set the date for the third session as seven-thirty tomorrow morning, so as not to conflict with scientific sessions. This session will be held in the Loraine Room

on the lobby floor. At that time we will receive the report of the Committee on Nominations.

It is also customary, Mr. Speaker, for the Secretary to announce in advance that the report of the Committee on Nominations does not preclude additional nominations from the floor.

Speaker Seeger: Is there any other business to come up at this time?

If not, we stand adjourned until tomorrow morning at seven-thirty o'clock.

. . . The meeting adjourned at eleven o'clock P. M. . . .

Adjournment

THURSDAY MORNING SESSION

September 15, 1932

The meeting was called to order at seven-thirty o'clock A. M., by Speaker Seeger.

Speaker Seeger: The first order of business is the report of the Committee on Credentials, Dr. Gramling, Chairman.

Dr. H. J. Gramling (Chairman, Committee on Credentials): Mr. Speaker: Your Committee on Credentials is pleased to report at this time the registration of twenty-six members of the House, including twelve Councilors.

No questions have been raised relative to the seating of Delegates or Alternates.

Slips for recording attendance having been passed out, I move that the attendance record so compiled constitute the roll of this session.

. . . The motion was seconded by Delegate C. A. Armstrong of Prairie du Chien, and carried . . .

Speaker Seeger: The next order of business is the Reports of Committees.

Are there any further reports from the Committee on Reports of Officers?

Delegate T. J. O'Leary (Superior, Chairman, Committee on Reports of Officers): Mr. Speaker, we have nothing further to report.

Speaker Seeger: Are there any further reports from the Committee on Reports of Standing Committees?

Delegate Gunnar Gundersen (La Crosse, Chairman, Committee on Reports of Standing Committees): Mr. Speaker, we have no further report.

Speaker Seeger: Are there any further resolutions to be offered by the Resolutions Committee, Dr. Carter, Chairman?

Delegate D. E. W. Wenstrand: There are no further resolutions, Mr. Speaker.

Speaker Seeger: Are there any other reports, Mr. Secretary?

Secretary Crownhart: No.

Speaker Seeger: Then the Secretary will give us the report of the Committee on Nominations.

ELECTIONS

Secretary Crownhart: Mr. Speaker, if I may repeat what I said last night, it is customary for the Secretary to state before reading the report of the Committee on Nominations, this does not preclude additional nominations from the floor.

The report of the Nominating Committee is as follows:

For President-Elect, Dr. Stanley J. Seeger of Milwaukee.

For Speaker of the House of Delegates, Dr. Ralph M. Carter of Green Bay.

For Vice-Speaker of the House of Delegates, Dr. W. G. Sexton of Marshfield.

For delegates to the American Medical Association, Dr. J. Gurney Taylor of Milwaukee, and Dr. W. E. Bannen of La Crosse.

For alternate delegates to the American Medical Association, Dr. F. Gregory Connell, Oshkosh, and Dr. T. W. Nuzum of Janesville.

. . . President Otho A. Fiedler, in the absence of Vice-Speaker M. D. Bird of Marinette, assumed the Chair . . .

Chairman Fiedler: Gentlemen, you have heard these nominations.

Are there any other nominations for President-Elect? (None) If not, the Speaker will entertain a motion that nominations be closed.

Delegate D. E. W. Wenstrand (Milwaukee): I move, Mr. Chairman, that nominations be closed, and that the Secretary be instructed to cast the unanimous ballot of the House of Delegates for Dr. Seeger for President-Elect.

. . . The motion was seconded by Delegate S. G. Higgins of Milwaukee . . .

Chairman Fiedler: Are you ready for the question?

. . . Question was called. The motion was put and unanimously carried. (Applause) . . .

Secretary Crownhart: The Secretary casts the unanimous ballot of this Society for Dr. Stanley J. Seeger as President-Elect. (Applause)

Speaker Seeger: I really do not know what to say to you men. I feel that this honor is the highest which the profession in the state can confer on one of its members, and because of the character of our Society is one of the outstanding things which can come to a man in his life time. I should like to say that it makes me feel very good and that I enjoy the sensation, but as a matter of fact I feel very humble, particularly when I reflect on the character and accomplishments of the men who have preceded me in this office. I hope to be able to measure up to it.

I believe that probably the only reason for this distinction conferred upon me is the work which has been done in Milwaukee County, where for about ten years it has been my privilege to be associated with the county organization. I should like to take this opportunity to say that what has been done in Milwaukee County has been accomplished only because of the hard work of a small group of devoted and loyal men, any one of whom, I am sure, is more deserving of favor at your hands than am I. I wish to thank you from the bottom of my heart. (Applause)

. . . Speaker Seeger resumed the Chair . . .

Speaker Seeger: The next office to be filled is that of Speaker of the House. The nominee of the Committee is Dr. Ralph M. Carter of Green Bay. Are there any other nominations? (None)

Delegate H. J. Gramling (Milwaukee): Mr. Speaker, I move that nominations be closed and the secretary be instructed to cast the unanimous ballot of the House of Delegates for Dr. Ralph M. Carter of Green Bay as Speaker of the House.

. . . The motion was seconded by Delegate J. F. Mauermann of Monroe and unanimously carried . . .

Secretary Crownhart: The Secretary casts the unanimous ballot of this Society for Dr. Ralph M. Carter as Speaker of the House. (Applause)

Speaker Seeger: To be Vice-Speaker of the House of Delegates, to succeed Dr. M. D. Bird of Marinette, Dr. W. G. Sexton of Marshfield. Are there any other nominations? (None)

Delegate R. W. Jones (Wausau): Mr. Speaker, I move that nominations be closed and that the Secretary be instructed to cast the unanimous ballot of the House of Delegates for Dr. W. G. Sexton of Marshfield as Vice-Speaker of the House.

. . . The motion was seconded by Delegate F. X. Pomainville of Wisconsin Rapids and unanimously carried . . .

Secretary Crownhart: The Secretary casts the unanimous ballot of this Society for Dr. W. G. Sexton as Vice-Speaker of the House. (Applause)

Speaker Seeger: Delegate to the American Medical Association, Dr. J. Gurney Taylor of Milwaukee to succeed himself. Are there any other nominations? (None)

Delegate F. F. Bowman (Madison): Mr. Speaker, I move that the nominations be closed and the Secretary instructed to cast the unanimous vote of this House of Delegates for Dr. J. Gurney Taylor as a delegate to the A. M. A.

. . . The motion was seconded by Delegate F. A. Thompson of Milwaukee and carried unanimously . . .

Secretary Crownhart: The Secretary casts the unanimous ballot of this Society for Dr. J. Gurney Taylor as a delegate to the A. M. A. (Applause)

Speaker Seeger: Next is the election of a delegate to succeed Dr. W. E. Bannen of La Crosse. The Committee nominates Dr. W. E. Bannen to succeed himself.

Delegate Gunnar Gundersen (La Crosse): Mr. Speaker, I move that nomination be closed and the Secretary instructed to cast the unanimous ballot of this House of Delegates for Dr. W. E. Bannen as a delegate to the A. M. A.

. . . The motion was seconded by Delegate A. E. McMahon of Glenwood City, and carried unanimously. . .

Secretary Crownhart: The Secretary casts the unanimous ballot of this Society for Dr. W. E. Bannen as delegate to the A. M. A. (Applause)

Speaker Seeger: For Alternate Delegate to the A. M. A. to succeed Dr. F. Gregory Connell of Oshkosh, the Committee nominates Dr. Connell to succeed himself.

Alternate Delegate R. B. Rogers (Neenah): Mr. Speaker, in a personal talk with Dr. Connell he wishes to be relieved of this, and have another nomination made.

Speaker Seeger: The floor is open now for nominations, which are not precluded by this nomination. You have heard the statement which has just been made. What is your pleasure in this matter?

Delegate Rogers: Personally, I think he should be nominated for the position, but he did say if it were possible to select someone in his place he would desire it.

Delegate H. T. Barnes (Delafield): Mr. Speaker, if he *will* serve, I move that nominations be closed and the Secretary instructed to cast the unanimous ballot of this House for Dr. F. Gregory Connell as Alternate Delegate to the A. M. A.

. . . The motion was seconded by Delegate D. J. Twohig of Fond du Lac and unanimously carried . . .

Secretary Crownhart: The Secretary casts the unanimous ballot of this Society for Dr. F. Gregory Connell as Alternate Delegate to the A. M. A. (Applause)

Speaker Seeger: The last is the election of an Alternate Delegate to the A. M. A. to succeed Dr. T. W. Nuzum of Janesville. The Committee nominates Dr. Nuzum to succeed himself.

Delegate J. F. Mauermann (Monroe): Mr. Speaker, I move that nominations be closed and the Secretary instructed to cast the unanimous ballot of this House of Delegates for Dr. T. W. Nuzum as Alternate Delegate to the A. M. A.

. . . The motion was seconded by Delegate S. G. Higgins of Milwaukee and unanimously carried . . .

Secretary Crownhart: The Secretary casts the unanimous ballot of this Society for Dr. T. W. Nuzum as Alternate Delegate to the A. M. A. (Applause)

Speaker Seeger: Is there any further business to come before the House?

Secretary Crownhart: Mr. Speaker, this clears the business on the desk of the Secretary. I would like to remind the delegates that, under your action taken a year ago, the next session of the House of Delegates, unless called into special session, will be at the time the American Medical Association meets in Milwaukee on dates to be arranged so they will not conflict with those meetings of the Association which you will, of course, wish to attend.

In accordance with custom, within one week of the adjournment of this House, the Secretary will endeavor to place in the hands of every delegate and every alternate a summary of the proceedings of this House. You can anticipate receiving that within one week. You will also receive a report as to your attendance. If there are any corrections to be made it is essential we have them promptly.

Mr. Speaker, I have no other business to come before the House.

Speaker Seeger: Has anyone any business to bring up?

If not, before declaring this meeting adjourned, I wish to thank the members of this House of Delegates for your attention and cooperation in transacting the business which we have had before us in the two long sessions last night and the night before. Were it not for your cooperation and close attention we would not have accomplished as much as we did.

I will entertain a motion to adjourn.

Delegate J. F. Mauermann (Monroe): Mr. Speaker, I move we adjourn.

. . . The motion was seconded by Delegate G. F. Adams of Kenosha, and carried . . .

. . . The meeting adjourned at seven-fifty o'clock A. M. . . .

Adjournment

Minutes of the Council

First Meeting, Hotel Schroeder, Milwaukee, 2:30 P. M. Tuesday, September 13, 1932.

1. *Roll Call.* Council was called to order at 2:30 P. M. Tuesday, September 13, by Dr. Arthur W. Rogers, Oconomowoc, Chairman. *Present:* Councilors A. W. Rogers, Oconomowoc; Frank W. Pope, Racine; C. A. Harper, Madison; Wilson Cunningham, Platteville; A. H. Heidner, West Bend; S. E. Gavin, Fond du Lac; Spencer D. Beebe, Sparta; T. J. Redelings, Marinette; Joseph F. Smith, Wausau; H. M. Stang, Eau Claire; F. G. Johnson, Iron River; R. W. Blumenthal, Milwaukee, and President O. A. Fiedler, Sheboygan; President-Elect Reginald H. Jackson, Madison; Speaker Stanley J. Seeger, Milwaukee; Treasurer Rock Sleyster, Wauwatosa; and the Secretary, Mr. J. G. Crownhart. The Council also had as guests Drs. S. M. B. Smith, Wausau, of the Committee on Public Policy, and J. F. Wilkinson, Oconomowoc, of the special committee of the Wisconsin Anti-Tuberculosis Association.

2. *Approval of Minutes.* Moved by Blumenthal–Pope that the minutes of the April meeting, published in the Wisconsin Medical Journal of May, 1932, be approved. Carried.

3. *Approval of Mail Ballots.* (A) Moved by Gavin–Smith that the statement to the members on legal danger involved in the aftercare of suspected abortion cases be approved. Carried. (B) Moved by Heidner–Redelings that the responsibility of the Treasurer and Secretary for Society funds in their possession be defined as follows:

> Having in mind that the Treasurer and Secretary will take the usual precautions to protect the funds of the State Medical Society of Wisconsin, the Council releases both officers from any responsibility which might otherwise arise out of losses incurred through bank failures or defaulted security investments.

Carried. (C) Moved by Harper–Smith that the Council award be granted to Dr. Mina B. Glasier, of Bloomington. Carried.

4. *The 1932 Budget.* (A) Moved by Blumenthal–Smith that an appropriation of $1800 be granted to cover $300 for the stenotype reporting and miscellaneous expenses of the 1933 meeting of the House of Delegates, and $1500 to complete the expenses of the annual dinner to officers and delegates of the American Medical Association on the occasion of their meeting in Milwaukee in June, 1933. Carried. (B) Moved by Gavin–Pope that the Council approve the item of $350 for the 1933 budget for the re-presentation of Hygeia subscriptions at Christmas time.

5. *Old Fort Winnebago Hospital Building.* The Secretary read a communication from Dr. James W. MacGregor, of Portage, suggesting Society action looking towards the preservation of the old Fort Winnebago Hospital building now over one hundred years old at Portage. Moved by Sleyster–Blumenthal that the Chairman of the Council appoint a committee of three to investigate this subject matter and to report at the next meeting of the Council. Carried. The Chairman appointed the committee to consist of Councilors Harper, Gavin, and Blumenthal.

6. *Forest County Charter.* The Secretary presented a communication from the Forest County Association of Physicians requesting a charter as a component county medical society under the State Medical Society. The Secretary explained that the charter must be granted by the House of Delegates but only after approval of the Council. Moved by Redelings–Johnson that approval of the Council be granted. Carried.

7. *Safety Lecturers.* The Secretary stated that the Industrial Commission of Wisconsin has requested the cooperation of the State Medical Society to the end that a physician might be designated to present a lecture on "Minor Infections—Their Importance" before Safety meetings of working men in some twenty cities of Wisconsin. After discussion it was moved by Blumenthal–Redelings that such lecturers be appointed by the President of the Society from members of the Society and with the advice of the President of the County Society under whose jurisdiction they would speak. Carried.

8. *Wisconsin Anti-Tuberculosis Association.* The special committee on the Wisconsin Anti-Tuberculosis Association reported its progress. (By action of the Council on Nov. 6th the report was placed on the table until the January meeting.)

9. *Committee on Public Policy.* Dr. Fiedler, Chairman, reported that the Committee had no ad-

ditional business to bring before this session of the Council.

10. *Adjournment.* There being no further business on the Secretary's desk the Council adjourned at 4:45 P. M.

MINUTES OF THE COUNCIL

Second Meeting of the Council, 5:30 P. M., Hotel Schroeder, Milwaukee, Wednesday, September 14, 1932.

1. *Roll Call.* The Council was called to order by Chairman Rogers with the following present: Councilors A. W. Rogers, Oconomowoc; Frank W. Pope, Racine; C. A. Harper, Madison; Wilson Cunningham, Platteville; A. H. Heidner, West Bend; S. E. Gavin, Fond du Lac; Spencer D. Beebe, Sparta; Joseph F. Smith, Wausau; G. R. Duer, Marinette; H. M. Stang, Eau Claire; F. G. Johnson, Iron River; R. W. Blumenthal, Milwaukee; and I. E. Shiek, Rhinelander; and President O. A. Fiedler, Sheboygan; President-Elect Reginald H. Jackson, Madison; Speaker Stanley J. Seeger, Milwaukee; Treasurer Rock Sleyster, Wauwatosa; and the Secretary, Mr. J. G. Crownhart. The Council had as guests at this meeting Drs. Wilbur N. Linn, George Reay, of La Crosse, and John E. Guy, of Milwaukee, all members of the committee on Legislation of the Wisconsin Homeopathic Society.

2. *Wisconsin General Hospital.* The Secretary prepared a proposed newspaper release on action of the House of Delegates with reference to the report of the special committee to investigate the State of Wisconsin General Hospital. Moved by Smith–Beebe that the release be approved. Carried.

3. *Invitation to Green Bay in 1934.* The Secretary announced that the Society was in receipt of an invitation to hold its 1934 meeting in Green Bay and stated that Councilors visiting in the vicinity should investigate the facilities that they might pass upon the invitation as to facilities at a subsequent meeting.

4. *Homeopathic Representation on State Board of Medical Examiners.* Members of the legislative committee of the Wisconsin Homeopathic Society and the Chairman of the Committee on Public Policy of the State Medical Society discussed with the Council the subject of composition of the State Board of Medical Examiners.

5. *Adjournment.* Council adjourned at 6:45 P. M.

MINUTES OF THE COUNCIL

Third Meeting of the Council, 3:30 P. M., Hotel Schroeder, Milwaukee, Thursday, September 15, 1932.

1. *Roll Call.* The Council was called to order by Chairman Rogers with the following present: Councilors Rogers, Stang, Harper, Smith, Duer, Heidner, Pope, Johnson and Cunningham; President Fiedler, President-Elect Jackson, Speaker Seeger, Secretary Crownhart. The Council had as guests at this meeting Drs. Reay and Guy.

2. *Homeopathic Society.* Drs. Reay and Guy presented the position of the Wisconsin Homeopathic Society to the Council.

3. *Wisconsin General Hospital.* At the request of Dr. Fiedler, the Council had a general discussion with reference to further procedures in carrying into effect the questions of the House of Delegates with respect to the State of Wisconsin General Hospital.

4. *Dues.* After discussion it was moved by Heidner–Smith that further authority be granted the Secretary to arrange with the secretaries of the component societies for partial payments of dues in certain specific cases without jeopardizing the right of the member to maintain medical defense. Carried.

5. *Adjournment.* Council adjourned at 4:30 P. M.

Report of Delegates to the American Medical Association

Your delegates from Wisconsin, Drs. Joseph F. Smith, F. Gregory Connell, and W. E. Bannen, submit the following report of proceedings of the House of Delegates of the American Medical Association in their 83rd annual session held at New Orleans, Louisiana, on May 9 to 13, 1932. There were 158 delegates seated, having filed proper credentials. During this convention your delegates from Wisconsin attended all of the meetings of the House of Delegates. The meetings were held on Monday morning, Tuesday morning, Tuesday afternoon and Thursday afternoon in the Tip Top Inn of the Roosevelt Hotel. The meeting was called to order at ten A. M. May 9 by the Speaker of the House, Dr. F. C. Warnshuis, who emphasized the importance of the deliberations in the House of Delegates as the legislative body for the American Medical Association, therefore, urging every delegate to be diligent in attendance; give thoughtful consideration and reflection before passing on policies and resolutions that would be brought before the House; and he also stressed the necessity for reference committees to use extreme care in bringing forth recommendations on subjects regarding which insufficient evidence or facts were submitted, to eliminate injudicious action, and prevent re-considerations and reversals of opinion at some subsequent session.

Committee appointments were made by the Speaker, and Dr. Joseph F. Smith of Wisconsin was placed on the important committee considering reports of officers. President, E. Starr Judd, was presented by the Speaker, and delivered an address in which he stressed the responsibility of the members of the House of Delegates, and discussed the

functions of the medical profession from a threefold viewpoint: First, to advise, treat, and care for those who are in need of the services of physicians; second, the planning of thorough programs of preventive medicine and public health; third, to protect the public in every manner possible against the activities of insufficiently educated or dishonest practitioners. He stressed the need of graduate training to enable a physician to keep up in modern medicine and modern methods of practice. He also spoke on the subject of specialization, and the investigation carried on by the Council on Medical Education and Hospitals to investigate the entire subject of specialization, and recommended that some form of regulation of specialization and proper qualifications of specialists be carried out. Dr. Judd then spoke of the problems of the medical profession and societies in advising on the subject dealing with the best plan for the care of war veterans, and the hope and confidence that the efforts of the Committee of the American Medical Association, of the American Legion, the Veterans Administration, and the American Hospital Association would bring forth a proper solution of this problem. Dr. Judd spoke of the need of the American Medical Association, more especially in its headquarters office, as the Association has outgrown the quarters in which it is housed.

Following President Judd, Dr. Edward Cary, President elect, spoke to the House of Delegates, stressing, not only the dual relationship of physcians, but the possibilities for graduated instruction. He stressed the work of the Bureau of Medical Economics in attempting to find some solution for the present social trends in the practice of medicine, and gave a glowing tribute to the work the American Medical Association is doing for the practitioners of medicine, both its members and those who are not enrolled as members. He stated no other organization in the world is giving its members so much as the American Medical Association. It embraces literature, news, information of all kinds pertaining to professions and standards, not to speak of associational advantages. He compared the cost of the British Medical Journal, which is next in size and importance to the Journal of the American Medical Association, and which costs $15 annually, while other foreign journals cost relatively the same. While the annual income of the average American physician is greater than in foreign countries, he expressed the hope that none of the constituent societies would take any action asking for a reduction of the cost of the Journal to its members, as it would be a backward step, and to the individual member would actually amount to very little. He, also, spoke of the need of the new home for the American Medical Association.

Before any other action of the House, it was addressed by Dr. Paul Wolfe of Berlin, bringing greetings from his country to the American Medical Association.

SECRETARY'S REPORT

Dr. Olin West, our Secretary, gave the first report on membership, in which he gave the total on March 1, 1932 as 99,470, compared with 98,807 for the same date in 1931. He spoke of the possibilities of increasing membership, but stated that the potential membership of the association could hardly exceed 110,000 at any time in the near future, even though all physicians eligible for membership could be brought into the affiliation. However, fellowship showed a marked decrease. On March 1, 1932, the number of Fellows enrolled was 64,712, or 224 less than on April 1, 1931, as reported at the Philadelphia session. He submitted a table from the various constituent state organizations showing the number of component county societies, the number of physicians in the state according to the Twelfth Edition of the American Medical Association Directory, and the number of doctors of the State Associations compared to the number of Fellows in the state. The report from Wisconsin showed 71 counties in the state; 51 component societies; one county not organized; 3104 physicians in the state; 2166 members of the State Society; and 1469 Fellows of the American Medical Association. That is 938 physicians in Wisconsin not members of the State Society, and 697 members of the State Society, who were not Fellows of the American Medical Association, and 1635 doctors who were not Fellows of the American Medical Association, or less than one-half. It is difficult to estimate with accuracy the number of these physicians who would be eligible for membership or fellowship, as those listed as doctors include inactive and retired physicians; young physicians who have not applied for membership, because they are not yet able to stand the expense involved; some of the older physicians not being members on account of expense; those young men serving terms as resident physicians in hospitals; and some who could not secure membership because they could not qualify as desirable applicants. He stated that it is true beyond question, that every effort should be made to bring into membership all physicians who are eligible, and who would aid in the furtherance of projects. He emphasized that quality should be the determining factor in membership. However, this membership analysis is of great importance to the American Medical Association and to the State Society and needs careful consideration.

The report of the Board of Trustees was long and exceedingly interesting showing the tremendous amount of work that these men, who meet once each month without pay, except their traveling expenses, give to the American Medical Association and to the physicians throughout the United States. Their responsibilities are great, being those of income and expenditures, building and equipment, and the activities of the Society throughout the year under their direct supervision. This report shows marked expansion of work in various Departments of the

Association for the past several years, and the work during 1931 has continued without curtailment.

The Committee on Legislative Administration has had a very heavy and active year and accomplished a great deal of work. The library staff has increased taking over a good deal of the work of the cumulative index medicus. The Library Committee expanded during the past year reporting incomes and expenditures during 1931, both from fellowship dues and subscriptions and advertising income, a gross income of $47,000 less than 1930. While the operating expenses in 1931 were $27,190 greater than in 1930. Also there was a marked depreciation in the value of real estate, buildings and equipment due to the times. The library in 1931 has expanded so that it was necessary to take over additional space. The circulating library has increased in efficiency, more than 7901 copies of periodicals were loaned to physicians and subscribers during 1931, an increase of 1500 over the previous year. The Library package service have sent out some 2450 package libraries, an increase of 400 or 20% over 1931, besides answering 3000 questions referred to the library during the year. The circulating library issued approximately 6,847 books during the year. The library now occupies practically the entire fifth floor of the association headquarters, and will require additional space with the growth of the service.

The Co-operative Medical Advertising Bureau earned approximately $1000 more than in 1930. The Council on Pharmacy and Chemistry, which has been operating for a quarter of a century, has kept up the work for which it has become recognized and so efficiently covers. New and nonofficial remedies have been carefully revised and brought abreast of the medical thought. The Chemical Laboratory has completed an enviable 25-year record for thoroughness and accuracy of work, and has been largely helpful to the Council on Pharmacy and Chemistry, and to other departments of the Association. The Committee on Foods, which is a new one, made great progress during the year, and 331 food products were carefully examined and reported on. Of the 331 products 274 have been acted upon finally and of these 178 have been accepted. The Physical Therapy Committee, created to protect the public against misleading statements and advertisers of physio-therapy equipment made noticeable advancement in the regulation of advertised claims of devices, and have evolved new standards on which to base therapeutic claims, although there is still much room for improvement. The Bureau of Health and Public Instruction has been active, and during the past year have broadcast radio health programs giving 325 talks. In addition to this 130 medical societies have been broadcasting health material to some degree; 5700 inquiries received were answered, as well as some 2750 inquiries submitted to Hygeia. Besides this a large number of educational pamphlets were issued by the Bureau, a total increase in number of 131,559 over work for 1930. The Bureau of Investigation is active, taking care of over 1000 letters a month.

The Bureau of Legal Medicine was active in federal legislation, although the 72nd Congress enacted no legislation of special interest. The proponents of the Sheppard–Towner legislation were unsuccessful. All bills relating to this were in the hands of the Committee at the close of the year. Some modifications were made regarding medicinal liquor, and four medical bills were pending at the close of Congress. Dr. Mayer on this Committee reported that he had made 36 trips to Washington in six years in the interest of medical legislation.

VETERANS' LEGISLATION

World War Veterans Relief Legislation of the 71st Congress made available $37,000,000 for additional hospital beds for veterans, and at the close of the year there was a bill pending before the 72nd Congress, authorizing $20,777,000 for additional beds for war veterans. The Council on Medical Education and Hospitals in January presented to this committee in Congress that there were 114,110 unoccupied beds in 3,902 government hospitals in the United States. The American Medical Association failed in its efforts to procure the abandonment of the government's policy to extend hospitalization and medical care in veterans' hospitals to veterans suffering with non-service connected diseases and injuries. However, the Committee on Legislative Activities reports that the joint committees of the American Legion, Veterans Bureau, American Hospital Association and American Medical Association finally reached a tentative agreement in which it was recommended that the Federal Hospital Building program would be curtailed, except for the erection of hospitals for the care of patients suffering from nervous or mental diseases and tuberculosis. Modifications of veterans' legislation have asked that veterans be taken care of in hospitals at home for all acute medical and surgical conditions, which shows considerable progress has been made along this line towards a solution of this program, and that legislation would be asked for along these lines with the convening of the next Congress. The most important steps along this line were the final establishment of permanent committees of all states representing the American Legion, American Hospital Association, Veterans Administration, and the American Medical Association, building for a better mutual understanding, and preparing the way for a change in policy which may come in the future. We cannot pass this committee without commenting on the splendid work contributed by the member of the Auxiliary Committee from Wisconsin, President Otho A. Fiedler, working in conjunction with the Committee of Legislative Activities and the educational work that he carried on throughout the state during the past year in regard to veterans' legislation.

Further discussion of the work of the Board of Trustees, which has been voluminous, would be

merely to mention the Bureau of Medical Economics, a newly organized bureau, and the great amount of work in the compilation of data on important subjects which this bureau has been doing during the past year from a medical and social standpoint. Perhaps the most pertinent of their activities is the work that has been done and will be reported soon, on the changes in questionnaires from health and accident insurance claims, and insurance death claims, and the probability of the International Claim Association allowing physicians a fee for filling in these questionnaires. Much space was given to the plans of this bureau for the year 1932. Report on the Bureau of Exhibits and the growth of this bureau, also the plans for the exhibit of the American Medical Association at the Century of Progress Fair to be held at Chicago in 1933. The various exhibits, including the scientific, at the meeting in New Orleans required a promenade of some five miles. Much was made of the field work done by the members of the Board of Trustees during the year 1931 and part of 1932 in visiting various state and other association meetings, and lastly the discussion of the Baker suit and its outcome. When one knows that the Board of Trustees is made up of nine members who have contributed so much, we cannot help but feel proud that our own well loved Rock Sleyster is a member of this Board, and congratulate him on being re-elected by the House of Delegates at the session in New Orleans.

Perhaps the next most important report was that of the Treasurer, of which we will mention only the most outstanding features. The net worth of the American Medical Association as of December 31, 1931 was $3,322,703.28. Net income for 1931 was $229,653.72. On this report one of the interesting features was a profit on sale of securities of $2,151.26. The total Association expenses were $330,401.69. This has been a very successful business year for the association. Other reports from the Council on Medical Education are hospital reports, reports on the Council on Scientific Assembly, and reports from the reference committees in which the resolutions brought before the House of Delegates were acted upon.

One of the interesting features was an address by General R. U. Patterson, Surgeon General of the United States Army, asking re-consideration of a resolution passed by the House of Delegates at the Philadelphia session, dealing with the moving of the Army Medical Library, commonly called the Surgeon General's Library, which at the present time consists of some very rare books numbering 333,202 bound volumes, great numbers of unbound volumes, and 880,677 pamphlets. He stated the present Surgeon General's Library comprises the largest collection of medical works in the world, and that this is well classified as the library began in 1879 to publish the index medicus turned over to the American Medical Association in 1927 and now published by it. The Surgeon General's Library has been thoroughly cataloged, and sends out more than 11,000 volumes to some 308 libraries throughout the country each year, so that anybody who wishes to get a book does not need to go to Washington, unless he desires to consult one of the rare books which are not sent out. However, it is essentially a part of the medical educational system of the Army of the United States, of the Navy, the Public Health Service, the Veterans Administration and the Army Medical Corps. The resolution would have transferred this Surgeon General's Library from the army medical center to the Library of Congress. After thorough discussion of the subject by the Surgeon General, a resolution was introduced to rescind the action of the House of Delegates at the Philadelphia session, and that it be recommended that the House of Delegates offer its co-operation in obtaining a suitable fire-proof building at the Army Medical center to house the Army Medical Library according to the plans of the War Department.

The session on Tuesday afternoon was given over to a special report by Dr. C. B. Wright on veterans' legislation in which he detailed the activities of the Auxiliary Committee on Veterans Administration to act with the Committee on Legislative Activities. There was a conference of all of the secretaries about November 30, 1931, at which the American Legion, American Hospital Association, and American Medical Association representatives were present. Another conference was held in Chicago December 30, 1931, at which the U. S. Veterans' Administration was also represented. The conference at Washington was held January 31, and again representatives of the Medical Advisory Council, American Hospital Association, American Legion, and American Medical Association were present. It was at this meeting that the tentative agreements were raised regarding a study of the costs of veterans' hospitals, and of non-federal hospitalization on like diseases. 2. A definite definition of an emergency case was agreed upon. 3. It was recommended that the hospital program of the American Legion regarding nervous diseases, mental disorders and tuberculosis be approved, including extension of hospitalization for care of these cases when necessary at home. By this extension of the hospital bill for general medical and surgical service, care of non-service connected cases would be discontinued in federal hospitals. 4. A committee, on motion of Dr. Cary, was to draw up an amendment to the existing law to permit veterans to be taken care of in their home hospitals. Dr. Woodward, Dr. Cliff and Dr. Faxon were appointed. It was recommended that liaison committees be organized in every state for its consideration. Representatives for the Hospital Association, State Medical Associations, State and Local American Legions, and representatives of the Veterans Administration lood toward better co-operation among these groups. 6. Mr. Hayes, representative of the American Legion, urged continued advice and co-operation on the part of the members of the medical and hos-

pital associations. Committees then adjourned to meet at the call of the chairman.

An attempt to evaluate the concrete value of the year's work is difficult. It is believed, however, that considerable was accomplished. The Shoulders Insurance Plan was not accepted, although a number of the legion posts throughout the country adopted the plan, and the work that was started along this line should be continued. This was one of the most important and favored of the reports submitted by any of the physicians. At the same time Dr. Wright and his committee reported on the Sheppard–Towner act. During this executive session the resolutions of the committee to study birth control were brought up. The reference committee reported as follows: This committee believes it would not be advisable at this time to inject this subject before the society. Therefore, this resolution of the reference committee was adopted. There was considerable discussion of the report of the committee on reports of the Board of Trustees and Secretaries. These contributed some fireworks, and resulted in the ironing out of some of the reference committee's statements or recommendations, before the report of the reference committee was adopted. Dr. Mayer's committee and report on the Committee on Medicinal Alcohol was heard at this executive session. Dr. Mayer's report was accepted and approbation extended for the splendid work they had done, although not many changes had been effected in the attitude of the department as regards medicinal alcohol.

ELECTION

The election of officers was on Thursday afternoon and Dr. Dean Lewis of Baltimore was elected president, although Dr. Hugh S. Cummings of Washington, and Dr. Walter L. Bearing of Iowa were well represented. The first ballot was Dr. Lewis 73; Dr. Cummings 47; Dr. Bearing 31. The second ballot was taken in which Dr. Lewis received 98 and Dr. Cummings 54. Dr. Rudolph Matas of New Orleans, was elected Vice-president. Dr. Olin West was re-elected Secretary by unanimous ballot. Dr. A. A. Hayden of Chicago was unanimously re-elected as Treasurer. Dr. F. C. Warnshuis was re-elected Speaker of the House for the ensuing year. Arthur Booth of New York was elected on the Board of Trustees to succeed Dr. Edward B. Heckel, who was not eligible for reelection. Dr. Joseph F. Smith, nominated Dr. Rock Sleyster to succeed himself as Trustee for a term of five years. Dr. Sleyster had a unanimous ballot and was re-elected.

The last business was the selection of a meeting place for the 1933 annual session. Atlantic City, Cleveland and Milwaukee had extended invitations. The Chairman of the Board of Trustees stated that the facilities of these cities had been investigated, and that they all had been found to have adequate facilities to accommodate a successful meeting of the Association. Dr. Gregory Connell extended the invitation from Milwaukee, from the state of Wisconsin and the State Medical Society. Dr. Walter P. Conway of New Jersey, extended the invitation for Atlantic City, and Dr. C. W. Stone extended the invitation from Cleveland. On the first ballot Milwaukee received 73 votes, Cleveland 44, and Atlantic City 11, and Milwaukee was designated the place for the next annual session of the American Medical Association. It might be said at this time that the Wisconsin delegation regretted extremely that Dr. Gurney Taylor was not present due to illness, and that the House of Delegates extended to him a telegram of regrets at his absence, and best wishes for his early recovery. The delegation from Wisconsin was very ably assisted in securing the place for Milwaukee's invitation before the convention by the Secretary of their State Society, George Crownhart, President-elect of the Milwaukee County Society, Dr. James Sargent, the Secretary of the Milwaukee County Medical Society, Mr. Wiprud, and the Secretary of the Chamber of Commerce, Mr. Ferguson. Without the help and cooperation of these gentlemen, and the previous assistance of our absent delegate, Gurney Taylor, the results might not have the large primary ballot for Milwaukee.

PROGRESS REPORT OF SPECIAL COMMITTEE ON DISTRIBUTION OF MEDICAL SERVICES IN WISCONSIN; STATE MEDICAL SOCIETY OF WISCONSIN, 1932

THE COMMITTEE

GILBERT E. SEAMAN, M. D., Chm. GUNNAR GUNDERSEN, M. D., La Crosse D. E. W. WENSTRAND, M. D., Milwaukee
J. G. CROWNHART, Secretary OTHO FIEDLER, M. D., President, ex-officio

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Progress Report of Special Committee on the Distribution of Medical Services in Wisconsin; State Medical Society of Wisconsin, 1932

To the 1932 House of Delegates:

This committee appointed by President Fiedler upon authorization of the 1931 House of Delegates submits the following report of progress. In the reading of this report the following fundamental facts should be kept in mind at all times:

1. Working with restricted funds and a small staff, we have endeavored to limit our studies to the obtaining of those facts which would give us a clear cut picture of the Wisconsin situation.

2. In the main your Committee has limited its efforts to fact-finding studies. Its conclusions and recommendations represent only thought of the Committee and are not to be interpreted as representing the thoughts of any others or the Society proper until after appropriate action by your House. The factual studies were made for the Committee by the Secretary of the Society, his assistant and office staff.

3. These studies are not presented as representative of anything else than our sincere effort. We frankly concede some probable percentage of error in our estimates and can only state that we have used every means that the report might not be biased.

Your Committee is in accord with the statement of Dr. David Cheever, Boston, when he declared that the profession of medicine and its practitioners "have no vested rights which are incompatible with public well-being". This basic truth has motivated every activity of your Committee, believing as we do that only by advancing the public interest may we truly and permanently advance the interests of each individual practitioner of medicine in this state. We urge that our studies be given your thoughtful consideration to the end that our Society as an organization may of itself suggest that social effort which will best promote for the future that joint and indivisible interest of the earnest practitioner of medicine and his patient.

Respectfully submitted,

GILBERT E. SEAMAN, Milwaukee, *Chairman.*
D. E. W. WENSTRAND, Milwaukee.
GUNNAR GUNDERSEN, La Crosse.
OTHO A. FIEDLER, *President, ex officio.*
J. G. CROWNHART, *Secretary.*

DISTRIBUTION OF PHYSICIANS IN WISCONSIN (1930)

	Population	Physicians (A. M. A. Directory)	Population per Physician
1910	2,333,860	2,520	926
1920	2,632,064	2,750	957
1930	2,939,006	3,100	948

A careful study to weed out physicians who are not practicing medicine actively reduces the state total in 1930 to 2,760. On this basis the population per physician in Wisconsin in 1930 was 1065. Our study of incomes indicated 2,836 in practice but this included those in partial practice so that the difference of 76 is only that occurring because of the independent basis for each of the two studies.

Recent data indicates that we are licensing three physicians in Wisconsin for each physician who dies. Taking into account removals from the state, however, and those who obtain a Wisconsin license but fail to use it, our data shows that the balance as between number licensed and the number needed (to replace those deceased, removing from the state and to care for added population) was only fractionally higher up to 1932.

For seven years the State Medical Society has gone far to assist in the placement of physicians. In the current period it is our experience that under the present economic pressure we are unable to suggest any locations in the state except for obvious replacements, few in number.

While we have some requests for physicians from community clubs and like groups, our present experience clearly indicates that there is no community in Wisconsin lacking the services of a physician who could support one without a frank subsidy in addition to such fees as he might collect in private practice. While there is no provision in the Wisconsin statutes for subsidies as such, this situation may be met by any community so desiring, by making the physician the health officer of the town, village, or city at a flat salary sufficiently attractive to make certain that the physician will be able to secure a living from the joint income of salary and fees.

To one not intimately acquainted with the state it might appear that some counties were in great need of services of physicians. A more careful analysis, however, will either indicate that improved roads make services from other centers readily available or that distribution of population makes it impossible for any physician to receive an income sufficient to support his family without a subsidy from the community.

In Douglas County, for instance, we have a county that has an area of 1,337 square miles with a population of 46,264, largely in Superior. The county has average length of 40 miles north and south and 36 miles average width east and west. There is but one physician resident in the county outside of the city of Superior. This physician lives in a community 35 miles from Superior but in recent years he, too, has found it essential to establish his practice in Superior though he still maintains his residence in the rural community and is available for evening, night and early morning calls. To say, however, that physicians are needed in Douglas County to serve communities outside of Superior is to over-

County	Number of Physicians	Population of County	Physicians per Population	Area of County Sq. Miles	Number of Families 1930
Adams	3	7,875	2,625	684	2,034
Ashland	20	20,706	1,035	1,082	4,776
Barron	25	43,303	1,732	885	8,082
Bayfield	6	14,786	2,464	1,503	3,579
Brown	67	71,085	1,061	529	15,954
Buffalo	9	15,301	1,700	687	3,704
Burnette	6	10,173	1,695	860	2,549
Calumet	12	16,810	1,401	324	3,954
Chippewa	30	37,428	1,248	1,039	8,217
Clark	17	34,069	2,004	1,218	7,905
Columbia	36	30,507	847	778	8,097
Crawford	11	16,782	1,525	579	3,980
Dane	154	115,068	747	1,202	28,268
Dodge	41	52,327	1,276	897	12,813
Door	10	18,093	1,809	469	4,290
Douglas	38	46,264	1,217	1,337	11,249
Dunn	15	27,044	1,803	869	6,523
Eau Claire	40	41,619	1,040	638	10,182
Florence	2	3,785	1,892	497	880
Fond du Lac	70	60,259	861	726	14,799
Forest	8	11,245	1,406	1,017	2,305
Grant	35	38,411	1,098	1,169	9,980
Green	15	21,900	1,460	593	5,886
Green Lake	12	13,817	1,151	360	3,742
Iowa	19	19,892	1,047	781	5,155
Iron	4	9,900	2,475	792	2,161
Jackson	6	16,340	2,723	990	3,884
Jefferson	39	36,961	947	552	9,886
Juneau	13	17,069	1,313	802	4,446
Kenosha	56	64,476	1,151	282	15,171
Kewaunee	10	16,032	1,603	337	3,874
La Crosse	52	55,565	1,069	481	13,366
Lafayette	17	18,514	1,083	642	4,692
Langlade	18	21,551	1,197	875	4,845
Lincoln	4	21,071	5,267	902	4,966
Manitowoc	41	59,377	1,448	602	13,963
Marathon	44	71,166	1,736	1,554	15,451
Marinette	23	33,447	1,454	1,415	7,648
Milwaukee	888	743,844	831	235	177,866
Monroe	31	28,746	927	937	6,840
Marquette	9	9,282	1,030	457	2,455
Oconto	13	26,014	2,001	1,118	5,817
Oneida	11	16,089	1,341	1,183	3,756
Outagamie	55	63,558	1,065	646	14,579
Ozaukee	12	17,500	1,458	233	4,320
Pepin	5	7,447	1,489	236	1,892
Pierce	20	20,981	1,049	563	5,352
Polk	13	26,537	2,411	935	6,311
Portage	28	33,845	1,253	812	7,286
Price	8	17,161	2,145	1,279	3,951
Racine	79	91,343	1,156	324	22,083
Richland	16	19,495	1,218	590	4,728
Rock	93	75,012	807	716	19,583
Rusk	7	16,049	2,292	925	3,654
St. Croix	21	25,390	1,209	735	6,152
Sauk	30	31,978	1,066	842	8,245
Sawyer	5	8,942	1,788	1,320	2,098
Shawano	18	33,470	1,304	1,158	7,374
Sheboygan	64	72,367	1,131	521	18,055
Taylor	6	17,649	2,941	991	3,877
Trempealeau	22	23,850	1,084	748	5,604
Vernon	23	28,465	1,228	821	6,791
Vilas	4	7,359	1,226	934	1,746
Walworth	40	31,231	781	560	8,484
Washburn	5	11,076	2,215	835	2,657
Washington	21	26,635	1,268	431	6,395
Waukesha	52	53,333	1,026	549	12,682
Waupaca	32	33,444	1,045	759	8,263
Waushara	13	14,198	1,092	646	3,671
Winnebago	68	77,895	1,146	459	19,002
Wood	30	38,187	1,232	809	8,751
71 Counties	2,760	2,969,390	1,065		713,576

look the fact that there is one physician just over the east boundary of the county and another two just over the south and southwest boundaries. This combined with three state trunk highways leading into Superior make a service available to all residents of the county and, while not a perfect service, it is sufficient so that we could not place a physician in any community in that county with any assurance that he could make a living.

Some years ago Dr. Pusey published an article in the Journal of the American Medical Association in which he made the statement that there was one county in Wisconsin with a population of 3,785 people who had the services of but one physician. The office of the State Medical Society promptly received countless letters from physicians who were ready and anxious to avail themselves of such an excellent location. It so happened that Dr. Pusey referred to Florence County. The only community of any size in Florence County is the county seat of Florence. Iron Mountain, Michigan, however, is but a few miles distant from one border as well as Niagara, Wisconsin. To the south a physician at Goodman, Marinette County is available. Those familiar with the territory appreciate that there may be a bare living for one physician, there is none for a second.

Another county referred to by Dr. Pusey was Adams in the central portion of the state. Adams county is largely a sandy area with two central communities within a mile of each other,—Adams and Friendship. There are three physicians in the two communities. To say because the population of Adams County is 7,875 that there is need for other physicians is to disregard services available from Wisconsin Rapids on the north, Coloma, Hancock, Westfield and Oxford on the east, Kilbourn on the south and Necedah on the west.

Nor does it follow that because the death of a physician is reported, there is immediate need of a replacement There are not a few physicians in the state who have retired and of whom it may be said that,.because of the bettered facilities of travel, their practice retired with them.

It is conceded that there are sections of the state where people live beyond a twelve or fifteen mile radius of the nearest physician. In this respect they have not the service of any citizen of Milwaukee or Dane counties but it is equally true that except as the road program is furthered, it is impossible to place them closer to medical services.

Summary

Our studies would seem to indicate that considering the several factors involved, the distribution of physicians in Wisconsin is not such as suggests the need of immediate remedial steps to better the availability of service for the comparatively few that live outside the easy travel radius.

Our studies of incomes further indicate that in communities having but one physician there were in 1930—

11 who had a gross income less than $3,000 but over $2,500,
11 who had a gross income less than $2,500 but over $2,000,
5 who had a gross income less than $2,000 but over $1,500, and
3 who had a gross income less than $1,500 but over $1,000.

These physicians are mainly older men. If they remain in these communities despite the great decreases in income that they presumably suffered in 1931 and will take in 1932, it is probably because they own their own home and are living partially on savings. It must be evident, however, that unless these 32 communities can offer some better financial inducements they may be without the services of physicians in the next few years to come. In other words, as the resident physicians pass from the picture, it may be impossible to replace them with younger men who have such a major investment at stake. Many of these communities will be served from neighboring towns but some few are of a size that would seem to warrant local service if finances can be arranged. As previously suggested, in such instances a salary as health officer can solve their problem.

All cities in Wisconsin with population of 25,000 or over are required by statutes to have full time health officers, and they are required by law to be a physician. This is violated in La Crosse, in which case they have a layman.

Some cities under 25,000 have full time health officers. Wausau has a full time health officer who is a layman. The health officer in West Allis is very largely full time and is a physician. In all cities from 5,000 to 25,000 with the exception of Wausau and West Allis, the health officers are not full time but are physicians in every instance.

It is of interest to note, however, that in the communities under 3,000 where physicians may, in many instances, require reasonable financial income in order to maintain a practice in a rural or essentially rural area, the law permits the towns and villages to employ laymen as health officers even though there may be a resident physician. In our study of this situation we find that in 1,663 towns and villages there are 962 laymen serving as health officers as compared to 701 physicians. Of the 701 physicians, 143 serve as health officers in more than one town or village; 37 are health officers in three towns or villages. Some few of these physicians act as health officer in as many as seven towns or villages.

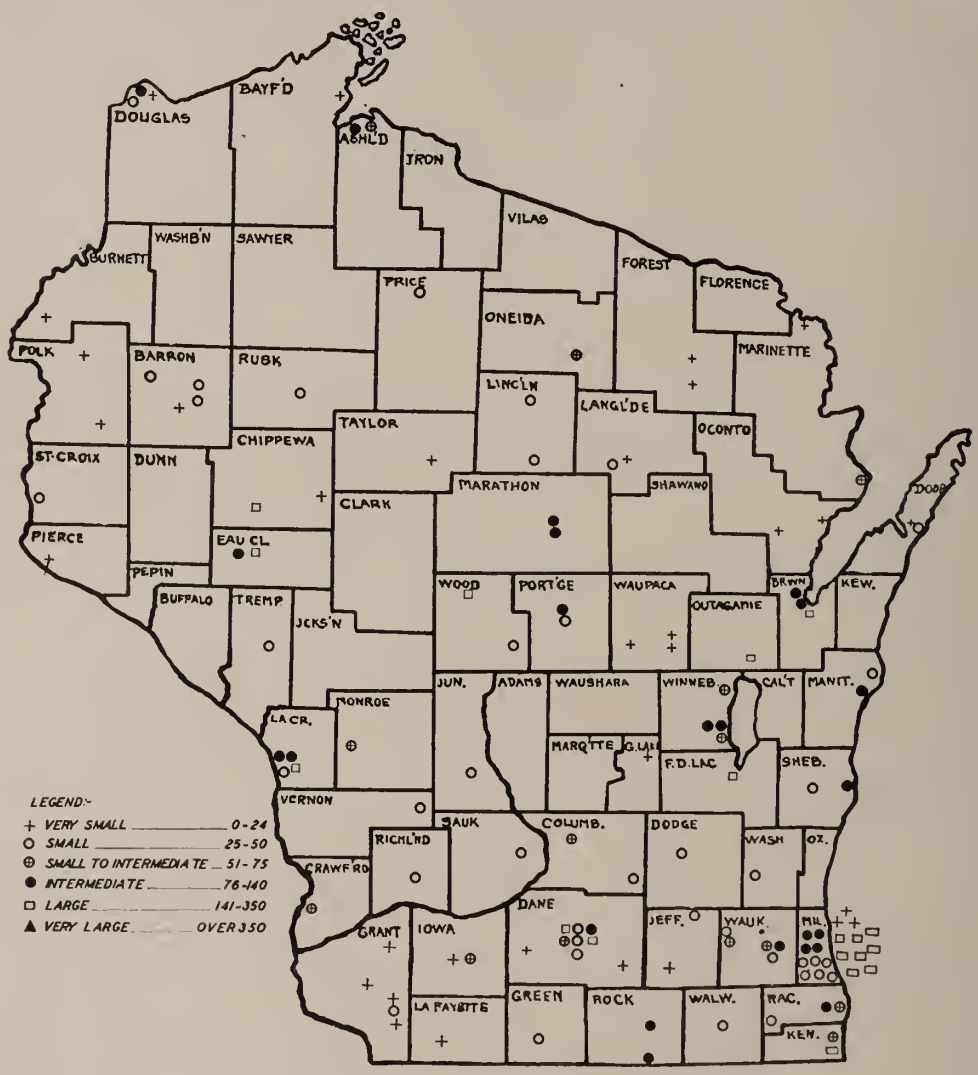
We recognize that even the physician, in his long years of training, who undertakes to serve as a health officer is entitled to receive additional specialized training. The ideal manner should be for such physician to attend a post graduate course at our state university but in many cases the com-

pensation is so inadequate (frequently as low as $50 a year) that any such procedure is financially impossible. Again the physician serving a small community, because he has no colleague within easy radius, frequently finds it impossible to leave for any length of time without inflicting a real hardship upon his patients.

Recognizing this situation it is our suggestion that the State Board of Health substitute for its biennial conference of health officers extension

(Continued on page 945)

DISTRIBUTION OF HOSPITALS IN WISCONSIN



For names of communities, see pages following.

Legend

While the Wisconsin General Hospital has 475 beds it is here listed in the "small" classification for the reason that only 35 beds are available for private patients. Likewise Milwaukee Children's Hospital is listed as "very small" because only 15 of their 155 beds are available for private patients. The Milwaukee County General Hospital is not included for the reason it has no private beds.

Of the 127 hospitals here listed eleven are in the nature of private sanitariums. The name and type of patient admitted follow:

Nervous and mental.
- Normandale, Madison.
- Sacred Heart Sanitarium, Milwaukee.
- St. Mary's Hill Sanitarium, Milwaukee.
- Oconomowoc Health Resort, Oconomowoc.
- Alexian Brothers Hospital, Oshkosh.
- Waukesha Springs Sanitarium, Waukesha.
- Milwaukee Sanitarium, Wauwatosa.
- Shorewood Hospital Sanitarium, Milwaukee.

Tuberculosis.
- River Pines Sanatorium, Stevens Point.
- Morningside Sanatorium, Madison.

Diabetes and internal medicine.
- The Spa, Waukesha.

There is included on this chart the sole hospital at Beloit which is owned by the municipality.

courses from time to time which will bring a high grade of instruction to those serving as health officers in every county in the state.

We must not lose sight, however, of the fact that even in a community with services of a physician immediately at hand, the people have a tendency to shop for medical services in larger centers for much that is not of an emergency service. The public can not "jump" the family physician when roads are good and the need not urgent and still expect to have him when the snow is deep. Plans can not be devised to afford medical services only for the few months in the year when the weather is bad.

The Hospitals in Wisconsin

In the United States in 1920 there was one hospital bed for community use for every 340 persons. By 1928 the hospitals had increased so greatly that there was one bed for each 270 persons. At the present time in Wisconsin there is one hospital bed for each 277 persons. This average is based on the 1930 census figure,—the population being 2,939,000.

127 Private Hospitals, Sanitariums and Sanatoriums by Counties

ADAMS COUNTY
ASHLAND COUNTY
Ashland General Hospital (66 beds), Ashland.
St. Joseph's Hospital (135 beds), Ashland.
BARRON COUNTY
River Side Hospital (12 beds), Barron.
Cumberland Hospital (27 beds), Cumberland.
Lakeside Methodist (33 beds), Rice Lake.
St. Joseph's Hospital (34 beds), Rice Lake.
BAYFIELD COUNTY
Washburn Hospital (18 beds), Washburn.
BROWN COUNTY
Bellin Memorial Hospital (92 beds), Green Bay.
St. Mary's Home and Hospital (98), Green Bay.
St. Vincent's Hospital (206 beds), Green Bay.
BUFFALO COUNTY
BURNETT COUNTY
Community Hospital (15 beds), Grantsburg.
CALUMET COUNTY
CHIPPEWA COUNTY
St. Joseph's Hospital (189 beds), Chippewa Falls.
Victory Hospital (15 beds), Stanley.
CLARK COUNTY
COLUMBIA COUNTY
St. Mary's Hospital (40 beds), Columbus.
St. Savior's General Hospital (63 beds), Portage.
CRAWFORD COUNTY
Prairie du Chien Sanitarium Hospital (60 beds), Prairie du Chien.
DANE COUNTY
Madison General Hospital (154 beds), Madison.
Madison Sanitarium & Hospital (51 beds), Madison.
Methodist Hospital (110 beds), Madison.
Morningside Sanatorium (35 beds), Madison.
Normandale (27 beds), Madison.
St. Mary's Hospital (175 beds), Madison.
Wisconsin General Hospital (35 private beds), Madison.
Buckner Hospital (14 beds), Mount Horeb.
Stoughton Community Hospital (22 beds), Stoughton.
DODGE COUNTY
Lutheran Deaconess Hospital (28 beds), Beaver Dam.
DOOR COUNTY
Egeland Hospital (25 beds), Sturgeon Bay.
Leasum Hospital (17 beds), Sturgeon Bay.
DOUGLAS COUNTY
Good Samaritan Hospital (12 beds), Superior.
St. Francis Hospital (50 beds), Superior.
St. Mary's Hospital (100 beds), Superior.
DUNN COUNTY
EAU CLAIRE COUNTY
Luther Bellinger Hospital (135 beds), Eau Claire.
Sacred Heart Hospital (210 beds), Eau Claire.
FLORENCE COUNTY
FOND DU LAC COUNTY
St. Agnes Hospital (220 beds), Fond du Lac.
FOREST COUNTY
Ovitz Hospital (18 beds), Laona.
Wabeno–Soperton Hospital (10 beds), Wabeno.
GRANT COUNTY
Brookside–Parker Hospital (22 beds), Boscobel.
Doolittle Hospital (12 beds), Lancaster.
Andrew Hospital (15 beds), Platteville.
Buck Hospital (12 beds), Platteville.
Wilson Cunningham Hospital (25 beds), Platteville.
GREEN COUNTY
Evangelical Deaconess Hospital (30 beds), Monroe.
GREEN LAKE COUNTY
Yates Memorial Hospital (16 beds), Berlin.
IOWA COUNTY
Dodgeville General Hospital (24 beds), Dodgeville.
St. Joseph's Hospital (54 beds), Dodgeville.
IRON COUNTY
JACKSON COUNTY
JEFFERSON COUNTY
Ft. Atkinson General (15 beds), Ft. Atkinson.
St. Mary's Hospital (50 beds), Watertown.
JUNEAU COUNTY
Mauston Hospital (45 beds), Mauston.
KENOSHA COUNTY
Kenosha Hospital (150 beds), Kenosha.
St. Catharine's Hospital (60 beds), Kenosha.
KEWAUNEE COUNTY
LA CROSSE COUNTY
Grandview Hospital (106 beds), La Crosse.
La Crosse Lutheran (140 beds), La Crosse.
Methodist Hospital (40 beds), La Crosse.
St. Francis Hospital (315 beds), La Crosse.
LAFAYETTE COUNTY
Dr. Ennis' Hospital (15 beds), Shullsburg.
LANGLADE COUNTY
Dr. Bloor's Hospital (10 beds), Antigo.
City Hospital (25 beds), Antigo.

LINCOLN COUNTY
Holy Cross Hospital (50 beds), Merrill.
Sacred Heart Hospital (45 beds), Tomahawk.

MANITOWOC COUNTY
Holy Family Hospital (100 beds), Manitowoc.
Two Rivers Hospital (37 beds), Two Rivers.

MARATHON COUNTY
St. Mary's Hospital (120 beds), Wausau.
Wausau Memorial Hospital (95 beds), Wausau.

MARINETTE COUNTY
Marinette & Menominee Hospital (60 beds), Marinette.
Niagara Hospital (12 beds), Niagara.

MARQUETTE COUNTY

MILWAUKEE COUNTY
Columbia Hospital (160 beds), Milwaukee.
Evangelical Deaconess Hospital (150 beds), Milwaukee.
Lincoln Hospital (25 beds), Milwaukee.
Dr. Lynch's Sanatorium (25 beds), Milwaukee.
Milwaukee Children's Hospital (15 private beds), Milwaukee.
Milwaukee General Hospital (200 beds), Milwaukee.
Milwaukee Hospital "The Passavant" (218 beds), Milwaukee.
Misericordia Hospital (109 beds), Milwaukee.
Mount Sinai Hospital (168 beds), Milwaukee.
Ogden Hospital (20 beds), Milwaukee.
Roger Williams Hospital (40 beds), Milwaukee.
Sacred Heart Hospital Sanitarium (320 beds), Milwaukee.
St. Joseph's Hospital (350 beds), Milwaukee.
St. Luke's Hospital (100 beds), Milwaukee.
St. Mary's Hill Sanitarium (120 beds), Milwaukee.
St. Mary's Hospital (210 beds), Milwaukee.
South Side Hospital (30 beds), Milwaukee.
West Side Hospital (25 beds), Milwaukee.
Shorewood Hospital–Sanitarium (50 beds), Shorewood.
South Milwaukee Hospital (16 beds), South Milwaukee.
Milwaukee Sanitarium (130 beds), Wauwatosa.

MONROE COUNTY
St. Mary's Hospital (75 beds), Sparta.

OCONTO COUNTY
Oconto County & City Hospital (20 beds), Oconto.
Oconto Falls Hospital (10 beds), Oconto Falls.

ONEIDA COUNTY
St. Mary's Hospital (65 beds), Rhinelander.

OUTAGAMIE COUNTY
St. Elizabeth's Hospital (200 beds), Appleton.

OZAUKEE COUNTY

PEPIN COUNTY

PIERCE COUNTY
Dr. Louis Jones' Hospital (20 beds), Prescott.

POLK COUNTY
Polk County Hospital (15 beds), Amery.
Frederic Hospital (24 beds), Frederic.

PORTAGE COUNTY
St. Michael's Hospital (111 beds), Stevens Point.
River Pines Sanatorium (50 beds), Stevens Point.

PRICE COUNTY
Park Falls Hospital (26 beds), Park Falls.

RACINE COUNTY
Burlington Memorial (29 beds), Burlington.
St. Luke's Hospital (125 beds), Racine.
St. Mary's Hospital (80 beds), Racine.

RICHLAND COUNTY
Richland Hospital (37 beds), Richland Center.

ROCK COUNTY
Beloit Municipal Hospital (90 beds), Beloit.
Mercy Hospital (120 beds), Janesville.

RUSK COUNTY
St. Mary's Hospital (35 beds), Ladysmith.

ST. CROIX COUNTY
Hudson Sanatorium (50 beds), Hudson.

SAUK COUNTY
St. Mary's–Ringling (25 beds), Baraboo.

SAWYER COUNTY

SHAWANO COUNTY

SHEBOYGAN COUNTY
Plymouth Hospital (35 beds), Plymouth.
St. Nicholas Hospital (128 beds), Sheboygan.

TAYLOR COUNTY
Medford Clinic Hospital (18 beds), Medford.

TREMPEALEAU COUNTY
Whitehall Community Hospital (40 beds), Whitehall.

VERNON COUNTY
Hansberry Hospital (25 beds), Hillsboro.

VILAS COUNTY

WALWORTH COUNTY
Walworth County Hospital (25 beds, private), Elkhorn.

WASHBURN COUNTY

WASHINGTON COUNTY
St. Joseph's Hospital (50 beds), Hartford.

WAUKESHA COUNTY
Summit Hospital (35 beds), Oconomowoc.
Oconomowoc Health Resort (75 beds), Oconomowoc.
The Spa (75 beds), Waukesha.
Waukesha Springs Sanitarium (50 beds), Waukesha.
Waukesha Municipal Hospital (120 beds), Waukesha.

WAUPACA COUNTY
Borchardt Clinic Hospital (16 beds), New London.
New London Community Hospital (11 beds), New London.
Dr. P. J. Christofferson Hospital (12 beds), Waupaca.

WAUSHARA COUNTY

WINNEBAGO COUNTY
Theda Clark Memorial Hospital (55 beds), Neenah.
Alexian Brothers Hospital (85 beds), Oshkosh.
Mercy Hospital (105 beds), Oshkosh.
St. Mary's Hospital (75 beds), Oshkosh.

WOOD COUNTY
St. Joseph's Hospital (155 beds), Marshfield.
Riverview Hospital (30 beds), Wisconsin Rapids.

Ownership of Hospitals

We are indebted to Dr. C. R. Bardeen for the following data relating to the types of hospitals in Wisconsin as of 1931.

It is to be noted that of the 13,099 beds for the care of the insane and feeble-minded, 94% are government owned (federal, state and county) with provisions for the acceptance of pay patients and that these government owned hospitals actually house 96% of the patients in this field.

Also, for the care of the tuberculous 95% of the hospital beds are government owned, also with provision for the acceptance of pay patients, and care for 96% of the patients.

Of the general hospitals the following facts are of importance:

1. Over one-half the general hospitals in Wisconsin have under a 50 bed capacity.
2. Over half the beds in this classification are in the large and very large institutions, from 140 beds up.
3. Some 12.3 of the institutions in this group are government owned and contain 20.2 of all the beds in this classification.

It is of more than passing interest to note that in the matter of the care of the insane or feebleminded the statutes provide that the relatives must pay if able but that in fact, comparatively few do so pay. Colonel Hannan of the State Board of Control estimates that if collections could be made from those able to pay, the minimum savings to the state would be in excess of $100,000 annually. We are inclined to believe that this figure is a modest one, and of course indicates that a larger sum is lost to the several counties upon whom falls the heavy burden of custodial care for the mentally ill. We suspect that the total loss to state and county would exceed $250,000 annually. Accepting Colonel Hannan's figures, it indicates that a state service is more subject to abuse by those able to pay than the services offered in private or church owned institutions. It is self-evident that Judges and District Attorneys upon whom rests the responsibility for determining who can pay, heretofore have not been sufficiently concerned with this feature when committing patients to institutions for the care of the insane or feebleminded. The State Board of Control is presently making a survey looking to the correction of this unnecessary and heavy expense upon the taxpayers. The department of outdoor relief in Milwaukee county has been exceptionally successful in this respect.

State Institutions

Care of the Insane

The total investment in the 42 institutions in the state for the care of the insane is:

State's investment	$ 3,775,611.28
36 counties	14,000,000.00
Improvement on county institutions	222,307.00
Milwaukee county	1,336,730.19
	$19,334,648.47

The state and counties spent $3,292,314.37 for operation and maintenance of the 42 institutions for the care of the insane in 1929 in caring for an average daily population of 9975 patients. This represents a per capita of $329.36 per patient per year, $6.33 per week or 90 cents per patient per day.

The state and counties spent $3,356,104.20 in 1930 in maintaining an average of 10,185 patients at an average per capita cost of $329.52 per year, $6.34 per week or 91 cents per patient per day.

Care of the Mentally Deficient

Investment in the two state institutions for the care of the mentally deficient is $2,757,475.78.

The state spent $501,836.43 during the year 1930 in caring for an average annual daily population of 1777 or an average annual per capita cost of $282.41, a weekly per capita cost of $5.45 or 77 cents per day.

Care of the Tuberculous

In Wisconsin we have one state sanatorium, one state rehabilitation camp, eighteen county sanatoria, one county preventorium and two private sanatoria. The Wisconsin State Sanatorium has a rated bed capacity of 94 beds. During the year 1930 the net disbursements were $213,520.58, the average daily population 155 and per capita cost per week $26.49. In 1929 the per capita cost per week was $22.87.

The Lake Tomahawk State Camp has a rated bed capacity of 40. For the year 1930 expenditures were $51,186.56, average population 39 and per capita cost $25.24 per week. The investment in land, buildings, equipment and furniture is $1,059,079.20.

County Facilities

On June 30, 1930, there were 1,383 patients under treatment in the 18 county sanatoria and the Douglas County Sanatorium for the care of the tubercular chronic insane.

The investment of the counties in these institutions is approximately $3,225,000. The net expenditures for operation, repair and maintenance of the institutions for 1930 were as follows:

County sanatoria (17)—65,857 weeks board furnished	
Douglas county—1,123 weeks board furnished	
County sanatoria (17)—Operation and maintenance expenses	$1,200,977.17
Douglas county—Operation and maintenance expenses	4,785.92
County sanatoria (17)—Average per capita cost	18.24
Douglas county—Average per capita cost	4.26

Number of Beds in Private Hospitals of Wisconsin

Hospitals with less than 50 beds:

61 hospitals with less than 50 beds have a total bed capacity of 1,397

(This includes the 15 private beds in Milwaukee Children's Hospital, 35 in Wisconsin General and 25 in Walworth County.)

(Continued on page 949)

HOSPITALS IN WISCONSIN, 1930
Data from A. M. A. 1931 Report

		Number	Beds	Patients	Average Beds	Average Patients
Feeble Minded	State	2	1,960	1,827	980	913.5
Insane	State	4	2,026	1,942	506.5	485.5
Insane	County	34	8,320	7,661	245.0	225.0
Total Public		40	12,306	11,430		
Feeble Minded	Church	1	300	300	300	300
Nervous and Mental	Independent	4	288	250	72	64.5
Nervous and Mental	Church	2	205	176	102.5	88
Total Private		7	793	726		
Tuberculosis	State	1	208	180	208	180
Tuberculosis	County	18	1,525	1,408	87.5	80.6
Total Public		19	1,733	1,588		
Tuberculosis	Independent	2	85	69	42.5	34.5
Sanitariums	Indep.	5	268	159	53.6	31.8
(General)	Indiv.	2	75	47	37.5	23.5
	Church	1	320	240	320	240
Total Private Gen. San.		8	663	446		
Isolation	City	6	397	133	66.1	22.2
Industrial	Indus.	2	30	15	15	7.5
General	Propr.	30	505	270	16.8	9.0
Very small	City	5	92	57	18	11
(Less than 24)	Church	1	12	9	12	9
	Assoc.	4	50	27	12.5	6.7
Total very small		42	689	378		
Small	County	3	106	66	35.5	22.0
(25-50)	City	1	35	28	35.	28
	Church	11	391	215	35.5	19.5 (one″)
	Assoc.	8	246	138	30.8	17.2 (one″)
Total small		23	778	447		
Small to intermediate (50 to 75)	Indian	1	60	20	60	20
	Church	10	560	318	56	31.8 (one″)
	Assoc.	3	182	125	61	42 (one″)
		14	802	463		
Intermediate (75-125)	City	2	220	53	110	26.5
	Church	14	1,570	986	112	70.4 (5″) (3″″)
	Assoc.	3	293	219	98	73 (1″″ (4″)
		19	2,083	1,258		
Large (140-350)	U. S.	1	250	212	250	212 (9*″)
	Church	13	2,702	1,603	208	123 (1 ″) (1*)
	Assoc.	7	1,170	756	167	108 (5*″) (1 ″)
		21	4,122	2,571		
Very large	State	1	475	413	475	413 ″T*
	County	1	1,000	395	1000	395 ″T*
		2	1,475	808		

″—recognized school of nursing
*—recognized for internships
T—recognized for residencies

Related Institutions

Wisconsin Veterans Hospital	1	147	115	Incur. Church	2	51	50
U. S. Veterans Home	1	797	730	Orph. Home Assoc.	1	18	18
State T. B. Camp	1	42	39	Institute N. & M. Church	1	35	10
Mar. County Home	1	45	42	Salv. Army Mat.	1	9	4
Milw. Co. Home Ch.	1	60	15	State & U. S. Acc.	5	85	47
Conv. Indust.	1	14	8				
Home Frat.	1	18	12		17	1,321	1,090

Total 218 consecutive numbers
2 interpol. B (La Crosse Methodist (small) Oconto City (very small)
1 not included because discontinued (Milwaukee Emergency)
221

	Number		Beds		Patients		
Feeble Minded and Insane	40		12,306		11,430	94%	94%
Private Insane	7		793		726	6%	6%
		47		13,099		12,156	
Tuber. Public	19		1,733		1,588	95%	96%
Independent	2		85		69	5%	4%
		21		1,818		1,657	
Sanitarium Hosp.		8		663		446	
Isolation		6		397		133	Over 2/3 patients in Instit. for custodian care. Less than 1/3 in instit. for treatment of acute dis.
Very small Hospital	42		689		378		
Small	23	Median	778		447		
Small to Inter.	14		802		463		Over half gen. hosp. small and very small. Over half beds in large and very large gen. hospital.
Intermediate	19		2,083	median	1,258		
Large	21		4,122		2,571		
Very large	2		1,475		808		
		121		9,949		5,925	
		17		1,321		1,090	
		220		27,247		21,407	

Omitting one hospital discontinued since A. M. A. report.

Number of Beds in Private Hospitals

(Continued from page 947)

Hospitals with 50 to 100 beds:
25 hospitals with 50 to 100 beds have a total bed capacity of 1,739

Hospitals with more than 100 beds:
30 hospitals with more than 100 beds have a total bed capacity of 4,994

8,130

Summary

The 116 hospitals have 1,365 bassinets.

The 11 private sanitariums and sanatoriums have a bed capacity of 1,017.

Cost of Construction and Equipment per Bed for Private Hospitals in Wisconsin

Hospitals with less than 50 beds:
25 hospitals in this group answered our question.
The 25 hospitals of less than 50 beds have a total bed capacity of 547 beds.
The average cost per bed is given as $2,489.11
The estimated total cost for the 547 beds is $1,361,543.17
There are 61 hospitals in Wisconsin with less than 50 beds. These 61 hospitals have a total bed capacity of 1,397 beds.
The estimated total cost for these 1,397 beds is $3,477,286.67*

Hospitals with 50 to 100 beds:
18 hospitals in this group answered our question.
The 18 hospitals of 50 to 100 beds have a total bed capacity of 1,233 beds.

* This figure is based on the average cost per bed as given by the 25 hospitals answering questionnaire.

The average cost per bed is	$2,784.04
The estimated total cost for the 1,233 beds is	$3,432,721.32
There are 25 hospitals in Wisconsin with 50 to 100 beds. These hospitals have a total bed capacity of 1,739 beds.	
The estimated total cost for the 1,739 beds is	$4,841,445.56*
Hospitals with more than 100 beds:	
18 hospitals in this group answered the question.	
The 18 hospitals with more than 100 beds have a total bed capacity of 2,750 beds.	
The average cost per bed is	$3,467.50
The estimated total cost for the 2,750 beds is	$9,535,625.00
There are 30 hospitals in Wisconsin with more than 100 beds. These 30 hospitals have a total bed capacity of 4,994 beds.	
The estimated total cost for the 4,994 beds is	$17,316,695.00
Estimated total cost for the 8,130 private beds in Wisconsin	
61 hospitals with less than 50 beds have a total of 1,397 beds with an estimated cost of	$3,477,286.67
25 hospitals with 50 to 100 beds have a total of 1,739 beds with an estimated cost of	4,841,445.56
30 hospitals with more than 100 beds have a total bed capacity of 4,994 beds with an estimated cost of	17,316,695.00
	$25,635,427.23

Indebtedness of Private Hospitals in Wisconsin

(On which interest must be paid)

Hospitals with less than 50 beds:	
24 hospitals answered the question on indebtedness.	
The *total indebtedness* of the 24 hospitals is	$746,689.61
The *average indebtedness* is	$31,112.06
These 24 hospitals have 568 beds.	
The *average indebtedness per bed* is	$1,314.59
The 61 hospitals with less than 50 beds have a total bed capacity of 1,397 beds.	
The estimated indebtedness for the 61 hospitals with 1,397 beds is	$1,836,482.73
Hospitals with 50 to 100 beds:	
12 hospitals in this group answered question.	
The *total indebtedness* of the 12 hospitals is	$1,696,131.75
The *average indebtedness* is	$141,344.31
These 12 hospitals have 883 beds.	
The *average indebtedness per bed* is	$1,920.87
The 25 hospitals with 50 to 100 beds have a total bed capacity of 1,739 beds.	
The estimated indebtedness for the 25 hospitals with 1,739 beds is	$3,340,392.93
Hospitals with more than 100 beds:	
20 hospitals answered the question on indebtedness.	
The *total indebtedness* of the 20 hospitals is	$5,678,862.90
The *average indebtedness* is	$283,943.14
These 20 hospitals have 3,176 beds.	
The *average indebtedness per bed* is	$1,788.05
The 30 hospitals with more than 100 beds have a total bed capacity of 4,994 beds.	
The estimated indebtedness for the 30 hospitals with 4,994 beds is	$8,919,511.70

Estimate Indebtedness for the 116 Private Hospitals in Wisconsin

The estimated indebtedness for the 61 hospitals of less than 50 beds, having a total bed capacity of 1,447 beds is	$1,836,482.73
The estimated indebtedness for the 25 hospitals of 50 to 100 beds, having a total bed capacity of 1,739 beds is	3,340,392.93
The estimated indebtedness for the 30 hospitals of more than 100 beds, having a total bed capacity of 4,994 beds is	8,919,511.36
	$14,096,387.36

Percentage of Occupancy in 1930

Hospitals with less than 50 beds reported an average occupancy of 69.8% in 1930 which decreased to 65% in 1931. Hospitals with 50 to 100 beds reported an average occupancy of 60.3% in 1930 which decreased to 58.2% in 1931. Hospitals with more than 100 beds reported an average occupancy of 66.6% in 1930 and 58.6% in 1931.

The American Medical Association* reported a study of 130 general hospitals in Wisconsin admit-

(Continued on page 956)

* This figure is based on the average cost per bed as given by the 18 hospitals answering questionnaire.

* Journal of American Medical Association, June 11, 1932.

STATE OF WISCONSIN HOSPITALS

City and Name of Hospital	Closed or Open Staff	Are Physicians who practice in nearby communities permitted personally to care for their patients in this Hospital?	Number on Staff	Is membership in the County Medical Society a prerequisite to staff membership?	Number of Internes	Number of Resident Physicians	Number of Operating Rooms	Number of Obstetrical Delivery Rooms	Number of Private Beds	Number of Bassinets
Amery Polk County Hospital	Open	Yes	2	Yes	0	0	1	1	15	5
Antigo Dr. Bloor's Hospital	Open	Yes	3	Yes	0	0	1	1	10	3
Antigo City Hospital	Open	No	6	No	0	0	0	0	25	5
Appleton St. Elizabeth's Hospital	Open	Yes	35	No	2	0	5	2	200	50
Ashland Ashland General Hospital	Open	Yes	16	Yes	0	0	2	1	66	8
Ashland St. Joseph's Hospital	Open	Yes	16	Yes	1	0	3	1	135	14
Baraboo St. Mary's-Ringling Hospital	Open	Yes	9	No	0	0	1	1	25	7
Barron Riverside Hospital	Closed	No	2	Yes	0	0	1	1	12	4
Beaver Dam Lutheran Deaconess	Open	Yes	------	Yes	0	0	1	1	28	8
Beloit Beloit Municipal	Closed	Yes	32	Yes	0	0	3	1	90	12
Berlin Yates Memorial	Open	Yes	------	No	0	0	1	1	16	2
Boscobel Brookside-Parker Hospital	Open	Yes	3	Yes	0	0	2	2	22	2
Burlington Burlington Memorial Hospital	Open	Yes	10	No	0	0	2	1	29	10
Chippewa Falls St. Joseph's Hospital	Open		12	No	0	0	4	2	189	16
Columbus St. Mary's Hospital	Open	Yes	5	--------	0	0	2	1	40	6
Cumberland Cumberland Hospital	Closed	Yes	3	Yes	0	0	1	1	27	7
Dodgeville Dodgeville General	Open	Yes	10	No	0	0	1	1	24	7
Dodgeville St. Joseph's	Open	Yes	10	Yes	0	0	2	1	54	10
Eau Claire Luther Hospital	Open	No	26	Yes	2	0	5	1	135	20
Eau Claire Sacred Heart Hospital	Open	No	34	Yes	0	0	6	1	210	15
Elkhorn Walworth County Hospital	Open	Yes	------	No	0	0	1	1	25	5

STATE OF WISCONSIN HOSPITALS—Continued

City and Name of Hospital	Closed or Open Staff	Are Physicians who practice in nearby communities permitted personally to care for their patients in this Hospital?	Number on Staff	Is membership in the County Medical Society a prerequisite to staff membership?	Number of Internes	Number of Resident Physicians	Number of Operating Rooms	Number of Obstetrical Delivery Rooms	Number of Private Beds	Number of Bassinets
Fond du Lac St. Agnes Hospital	Open	Yes	37	Yes	4	0	4	2	220	35
Ft. Atkinson Ft. Atkinson General	Closed	No	6	Yes	0	0	1	1	15	3
Frederic Frederic Hospital	Closed	Yes	5	Yes	0	0	1	0	12	5
Grantsburg Community Hospital	Open	Yes	4	No	0	0	1	1	15	4
Green Bay Bellin Memorial Hospital	Open	Yes	40	Yes	0	0	2	1	92	10
Green Bay St. Mary's Hospital	Open	Yes	50	Yes	0	0	4	2	98	22
Green Bay St. Vincent's Hospital	Open	Yes	60	Yes	0	0	6	2	206	14
Hartford St. Joseph's Hospital	Open	Yes	8	No	0	0	4	1	50	6
Hillsboro Hansberry Hospital	Open	Yes	2	No	0	0	1	1	25	3
Hudson Hudson Sanitarium	Open	Yes	2	Yes	0	0	1	1	50	2
Janesville Mercy Hospital	Closed	Yes	33	Yes	1	0	5	2	120	30
Kenosha Kenosha Hospital	Open	Yes	45	Yes	0	0	4	2	150	30
Kenosha St. Catharine's Hospital	Open	No	21	Yes	0	0	3	1	60	12
La Crosse Grandview Hospital	Closed	No	5	Yes	0	1	2	1	106	10
La Crosse La Crosse Lutheran	Closed	No	10	Yes	2	1	3	1	140	9
La Crosse Methodist Hospital	Closed	Yes	22	Yes	0	0	2	1	40	10
La Crosse St. Francis Hospital	Open	Yes	32	Yes	4	0	6	2	315	40
Ladysmith St. Mary's Hospital	Open	Yes	3	Yes	0	0	2	1	35	8
Lancaster Doolittle Hospital	Closed	No	2	Yes	0	0	2	1	12	2
Laona Ovitz Hospital	Closed	No	2	Yes	0	0	1	1	18	6
Madison Madison General	Open	No	34	Yes	4	1	8	2	154	26

STATE OF WISCONSIN HOSPITALS—Continued

City and Name of Hospital	Closed or Open Staff	Are Physicians who practice in nearby communities permitted personally to care for their patients in this Hospital?	Number on Staff	Is membership in the County Medical Society a prerequisite to staff membership?	Number of Internes	Number of Resident Physicians	Number of Operating Rooms	Number of Obstetrical Delivery Rooms	Number of Private Beds	Number of Bassinets
Madison Methodist Hospital	Closed	No	10	Yes	4	1	5	1	110	10
Madison St. Mary's Hospital	Open	No	40	Yes	5	1	5	2	175	30
Madison Wisconsin General Hospital	Closed	No	66	Yes	14	12	6	1	35	5
Manitowoc Holy Family Hospital	Open	Yes	28	Yes	0	0	5	2	100	25
Marinette Marinette & Menominee	Closed	Yes	5	Yes	0	0	1	1	60	12
Marshfield St. Joseph's Hospital	Closed	No	14	Yes	2	1	4	1	155	15
Mauston Mauston Hospital	Closed	No	4	Yes	0	0	1	1	45	6
Medford Medford Clinic Hospital	Closed	Yes	3	Yes	0	0	2	1	18	5
Merrill Holy Cross Hospital	Open	----------	------	--------	0	0	3	1	50	11
Milwaukee Columbia	Closed	Yes	65	Yes	4	1	6	1	160	24
Milwaukee Evangelical Deaconess	Open	Yes	61	Yes	4	0	4	1	150	30
Milwaukee Lincoln	Closed	No	2	Yes	0	0	1	1	25	0
Milwaukee Dr. Lynch's Sanatorium	Open	Yes	------	No	0	0	1	1	25	0
Milwaukee Milwaukee Children's	Closed	Yes	73	Yes	7	2	2	0	15	0
Milwaukee Milwaukee General	Closed	Yes	63	Yes	3	0	4	3	200	40
Milwaukee Milwaukee Hospital	Open	Yes	32	Yes	6	1	7	2	218	32
Milwaukee Misericordia Hospital	Open	Yes	70	Yes	2	1	3	2	109	30
Milwaukee Mount Sinai Hospital	Open	Yes	37	Yes	5	1	4	1	168	33
Milwaukee Roger William Hospital	Open	Yes	20	Yes	0	0	1	1	40	6
Milwaukee St. Joseph's Hospital	Open	Yes	120	Yes	6	1	11	3	350	72
Milwaukee St. Luke's Hospital	Closed	Yes	30	Yes	0	1	2	2	100	17

STATE OF WISCONSIN HOSPITALS—Continued

City and Name of Hospital	Closed or Open Staff	Are Physicians who practice in nearby communities permitted personally to care for their patients in this Hospital?	Number on Staff	Is membership in the County Medical Society a prerequisite to staff membership?	Number of Internes	Number of Resident Physicians	Number of Operating Rooms	Number of Obstetrical Delivery Rooms	Number of Private Beds	Number of Bassinets
Milwaukee St. Mary's Hospital	Open	Yes	40	No	1	0	9	2	210	35
Milwaukee South Side Hospital	Open	Yes	6	No	0	0	1	1	30	10
Milwaukee West Side Hospital	Open	Yes	20	Yes	0	0	1	1	25	5
Monroe Evangelical Deaconess					0	0	1	1	30	12
Mount Horeb Buckner Hospital	Closed		1	Yes	0	0	1	1	14	6
Neenah Theda Clark Memorial	Open	Yes	12	Yes	0	0	1	1	55	17
New London Borchardt Clinic Hospital	Open	Yes	2	No	0	0	1	1	16	6
New London New London Community Hosp.	Open	Yes	12	No	0	0	2	1	11	4
Niagara Niagara Hospital	Open	Yes	2	Yes	0	0	1	1	12	4
Oconomowoc Summit Hospital	Closed	Yes	10	Yes	0	0	2	1	35	6
Oconto Oconto County & City Hosp.	Open	Yes	3	No	0	0	1	1	20	4
Oconto Oconto Falls Hospital	Open	Yes	6		0	0	1	0	10	3
Oshkosh Mercy Hospital	Open		35		3	0	8	0	105	
Oshkosh St. Mary's Hospital	Open	Yes	34	Yes	1	0	1	3	75	25
Park Falls Park Falls Hospital	Closed	Yes	4	No	0	0	1	1	26	6
Platteville Andrew Hospital	Closed	Yes	2	No	0	0	1	1	15	6
Platteville Buck Hospital	Open	Yes		Yes	0	0	1	1	12	4
Platteville Wilson Cunningham Hospital	Closed	No	2	Yes	0	0	1	1	25	6
Plymouth Plymouth Hospital	Open	Yes	21		0	0	2	1	35	8
Portage St. Savior's General Hospital	Closed	No	12	Yes	0	0	3	1	63	7
Prairie du Chien Prairie du Chien Hospital	Open	Yes	3	Yes	0	0	2	2	60	6

STATE OF WISCONSIN HOSPITALS—Continued

City and Name of Hospital	Closed or Open Staff	Are Physicians who practice in nearby communities permitted personally to care for their patients in this Hospital?	Number on Staff	Is membership in the County Medical Society a prerequisite to staff membership?	Number of Internes	Number of Resident Physicians	Number of Operating Rooms	Number of Obstetrical Delivery Rooms	Number of Private Beds	Number of Bassinets
Prescott Dr. Louis Jones' Hospital	Open	Yes	3	No	0	0	1	0	20	4
Racine St. Luke's Hospital	Open	Yes	20	Yes	0	0	4	3	125	41
Racine St. Mary's Hospital	Closed	Yes	47	Yes	0	0	2	2	80	18
Rhinelander St. Mary's Hospital	Open	------	------	------	0	0	1	1	65	12
Rice Lake Lakeside Methodist	Open	Yes	21	Yes	0	0	1	1	33	5
Rice Lake St. Joseph's Hospital	Closed	Yes	7	Yes	0	0	1	3	34	4
Richland Center Richland Hospital	Open	Yes	20	No	0	0	2	1	37	8
Sheboygan St. Nicholas Hospital	Open	Yes	------	Yes	0	0	5	2	128	27
Shorewood Shorewood Hosp.-Sanitarium	Open	Yes	4	Yes	1	0	0	0	50	------
Shullsburg Dr. Ennis's Hospital	Closed	No	2	Yes	0	0	1	1	15	2
South Milwaukee South Milwaukee Hospital	Open	Yes	6	No	0	0	1	1	16	8
Sparta St. Mary's Hospital	Open	Yes	7	No	0	0	3	1	75	10
Stanley Victory Hospital	Open	Yes	------	No	0	0	1	1	15	6
Stevens Point St. Michael's Hospital	Closed	Yes	12	Yes	0	0	3	1	111	14
Stoughton Stoughton Community Hosp.	Open	Yes	7	Yes	0	0	1	1	22	9
Sturgeon Bay Egeland Hospital	Open	Yes	4	Yes	0	0	1	1	25	2
Sturgeon Bay Leasum Hospital	Open	Yes	2	No	0	0	1	1	17	5
Superior Good Samaritan Hospital	Open	------	------	------	0	0	1	1	12	8
Superior St. Francis Hospital	Open	Yes	4	No	0	0	1	1	50	10
Superior St. Mary's Hospital	Open	No	33	Yes	1	0	3	1	100	16
Tomahawk Sacred Heart Hospital	------	Yes	3	Yes	0	0	1	1	45	2

STATE OF WISCONSIN HOSPITALS—Continued

City and Name of Hospital	Closed or Open Staff	Are Physicians who practice in nearby communities permitted personally to care for their patients in this Hospital?	Number on Staff	Is membership in the County Medical Society a prerequisite to staff membership?	Number of Internes	Number of Resident Physicians	Number of Operating Rooms	Number of Obstetrical Delivery Rooms	Number of Private Beds	Number of Bassinets
Two Rivers Two Rivers Hospital	Open	Yes	8	Yes	0	0	2	1	37	6
Washburn Washburn Hospital	Open	Yes	4	Yes	0	0	1	1	18	5
Watertown St. Mary's Hospital	Open	----------	14	Yes	0	0	2	1	50	10
Wabeno Wabeno-Soperton Hospital	Closed	Yes	2	Yes	0	0	1	1	10	------
Waukesha Waukesha Municipal	Open	Yes	------	Yes	0	0	4	2	120	18
Waupaca Dr. P. J. Christofferson	Open	Yes	4	Yes	0	0	2	0	12	------
Wausau St. Mary's Hospital	Closed	Yes	15	Yes	0	0	5	1	120	18
Wausau Wausau Memorial Hospital	Open	Yes	21	Yes	0	0	4	1	95	15
Whitehall Whitehall Community Hospital	Closed	No	3	Yes	0	0	2	1	40	4
Wisconsin Rapids Riverview Hospital	Open	Yes	10	Yes	0	0	1	1	30	8

ting 184,965 patients in 1931 through the use of a bed capacity of 10,931 and 1,488 bassinets. Thus the average number of patients in these 10,931 beds was 6,614 which corresponds closely to the percentage of occupancy discovered upon our independent investigation in 1932.

The reference referred to in the footnote contains a great deal of correlated information concerning Wisconsin hospitals and hospitals generally.

Incomes of All Citizens in Wisconsin for the Year 1930

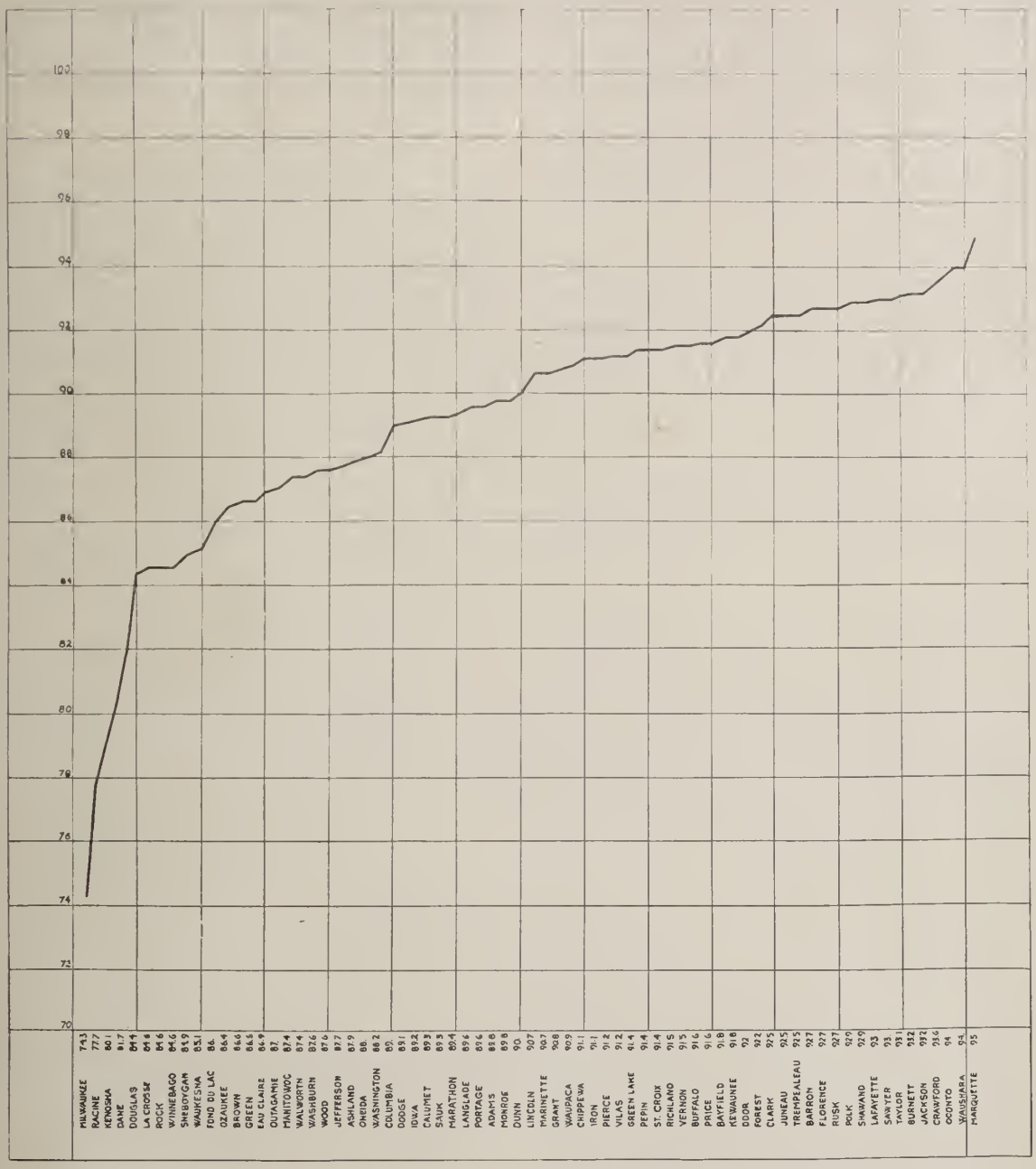
In any study on the cost of illness it is essential to have data relating to the cash incomes of the earners of the state. While the cash income does not represent the total income for those who live upon the land, after all it is from cash income plus savings that the costs of illness, payable in cash, must be met. While we can secure little data of value with respect to savings because averages are useless for our purposes here, we can secure data on cash incomes.

It is the belief of those making the study that the incomes of physicians in this state for the year 1930 represents very nearly what might be termed a normal year. Naturally the incomes reported in these pages suffered markedly during 1931 and 1932.

This report is made by chart which graphically portrays that portion of the state's earners by counties who have cash incomes of $1600 or less. The study upon which this is based is too long and too detailed to permit of inclusion in any other manner. All figures and data were secured under the personal supervision of the Wisconsin Tax Commission and based upon records in that department. It will be of interest to the reader to know that the masterbook of compilations from which this chart was made comprehends more than eighty pages of tables.

Incomes of Physicians in Wisconsin for the Year 1930

Working with limited funds and limited help, with several studies to complete in a nine months' period, the original intent to secure an average of incomes of physicians for the years 1928, 1929 and 1930 had to be abandoned for a study of the year 1930 alone. Using just 1930 figures, the large mas-



terbook required over 15,000 entries. As we traveled the state, however, to visit the 23 tax districts,* it was evident from the perusal of figures for the previous years that the depression period did not affect physicians in Wisconsin to any very marked degree before the early fall of 1930.

As in previous studies, the reader is advised not to draw, or attempt to draw, any further deductions from this study than are made in the report itself. Any effort to draw such deductions will lead to false and misleading conclusions.

* Kenosha, Racine, Janesville, Monroe, Madison, Jefferson, Milwaukee, Plymouth, Fond du Lac, Portage, Baraboo, Viroqua, La Crosse, Eau Claire, Wisconsin Rapids, Appleton, Manitowoc, Green Bay, Wausau, Phillips, Rhinelander, Ashland and Superior.

Definitions

It is pointed out that there is nowhere in this study an average income for a Wisconsin physician. Any such figure would be entirely fictitious, misleading and inaccurate. This study is based on (1) size of community (2) type of practice and (3) years in practice. There can be no average which overlooks these elementary considerations.

In referring to (2) type of practice, a surgeon or other specialist is so designated solely on the basis of receiving the major source of his income from such practice. Thus one is entered as a surgeon if the major portion of his gross income is derived from surgery.

To arrive at the number of years of practice the base line (0) is taken one year after date of graduation from medical school. While many physicians spent more than the intern year in postgraduate work, there are many older men of whom an intern year was not required. Undoubtedly many physicians take postgraduate work for a short period each year. It would involve numerous studies, beyond our present abilities to pursue, to determine the exact time each of the 2,836 physicians in Wisconsin spent as interns, residents or postgraduate students. It is not believed that such a study would materially change the general aspect of the figures here reported.

Particularly is it to be noted that throughout this report the word "income" means cash income received during the calendar year of 1930 from the so-called private practice of medicine only. Thus we do not include salaries paid physicians as instructors at the Universities of Marquette or Wisconsin; we do not include salaries paid physicians who are employed full time in public health work, nor moneys received that represent anything except return for services rendered in the capacity as a physician. Nor have we included interest from investments or accumulated savings.

The term "gross income" means gross cash income before expense of doing business has been deducted.

The term "expense" means those expenses of carrying on practice that are commonly recognized and approved by both state and federal income tax departments as legitimate deductions for physicians on income tax returns. Included in expense will be found such items, for instance, as a 20% depreciation on an automobile used entirely in the practice, a 10% depreciation on surgical equipment and other instruments, cost of gasoline used in making professional calls, cost of carrying professional insurance and membership in scientific professional societies, expense of an office assistant, office rent and like miscellaneous items of overhead expense common to all physicians. That these items have not been "padded" is best evidenced by the fact that it was obvious to us who made the study that many physicians overlooked even common expenses and all entries were approved by income tax authorities.

The term "net income" means net cash income, after deduction of expenses, from the practice of medicine only, received during the calendar year of 1930.

It will be suggested by some that, in addition to cash income, physicians receive a considerable value from payment in kind. Separate inquiry discloses that there was comparatively little payment in kind in this state during the year 1930. It is presently (1932) an item in all but the larger cities of the state.

Source of Study

While the American Medical Association Directory of 1930, used in tracing the income tax returns for this study, listed 2,987 physicians in Wisconsin, it was found that 30 received their entire income from public health work, 87 were definitely retired, 17 were largely engaged in other pursuits with little or no income from the practice of medicine, and 17 others appeared to derive their major income from government positions such as Veteran's Bureau, etc. This would seem to indicate that for the year 1930 there were 2,836 physicians in the state engaged in the active practice of medicine. Returns were found for 2,129 who were in active practice,—75% of the 2,836 physicians active in the state.

The failure here to include 707 returns is due to many reasons:

A. Some 67 physicians died during the year for whom no report was filed.

B. At least 60 physicians moved within the state during the year and their reports were filed in their new tax district. Another 50 had moved the previous year but made reports to their old district.

C. Some physicians had their office and address in one tax district but held legal residence in some other county and such reports could not be traced without great effort. This was true in the case of an estimated 100.

D. Of course some were ill during the year and their financial returns did not warrant or require tax reports. Possibly another 50 would fall into this classification.

E. Not infrequently a file in the income tax district was not found by reason of current use for auditing, or by other reason of office management.

F. Many older physicians apparently failed to keep accounts of value for income tax report purposes, accepting assessments levied by the assessor.

G. By reason of entering upon practice late in the year, some failed to earn amounts requiring tax returns.

H. Others apparently failed to earn taxable incomes even though in practice for the full year. In part this was due to advanced age and living secured from independent income.

SUMMARY OF STUDY OF INCOMES OF 2129 WISCONSIN PHYSICIANS FOR THE YEAR 1930

(Bold face numbers in headings indicate years in practice)

Number of years in practice	**0-4**				**5-9**				**10-19**				**20-29**				**30-34**				**35-39**				**40 & over**			
	Number of Physicians	Average Gross	Average Expense	Average Net	Number of Physicians	Average Gross	Average Expense	Average Net	Number of Physicians	Average Gross	Average Expense	Average Net	Number of Physicians	Average Gross	Average Expense	Average Net	Number of Physicians	Average Gross	Average Expense	Average Net	Number of Physicians	Average Gross	Average Expense	Average Net	Number of Physicians	Average Gross	Average Expense	Average Net
Average Income of the General Practitioner:																												
Living in communities of less than 2,000	24	5345	2357	2988	27	6946	3435	3511	85	5384	2306	3078	135	5169	2586	2582	59	3542	1832	1710	30	3857	1765	2092	25	2773	1287	1486
Living in communities of 2,000 to 10,000	25	4275	1809	2466	23	6273	2915	3358	58	7431	3582	3849	73	6128	3095	3033	32	4496	2025	2471	38	3984	2057	1927	26	3071	1247	1824
Living in communities of 10,000 to 25,000	7	5419	1636	3783	8	7255	2577	4678	17	5461	2601	2860	28	6490	3240	3250	18	5447	2250	3197	9	3465	1837	1628	11	3043	1606	1437
Living in communities over 25,000	40	5041	1822	3219	31	6631	2773	3858	63	6669	2705	3964	72	5526	2395	3131	25	4988	2197	2791	12	3980	1475	2505	21	3059	1386	1673
Living in Milwaukee County	58	3980	1674	2306	66	5814	2360	3454	94	6893	2853	4040	119	5461	2224	3237	55	5278	2235	3043	21	4861	2568	2293	25	3963	1927	2063
Average Income of the Surgeon:																												
Living in communities of less than 2,000	3	8781	2889	5892	6	11003	4420	6583	8	16474	9122	7352	6	11882	5153	6729	1	7818	2319	5499								
Living in communities of 2,000 to 10,000	5	9566	2919	6647	7	12920	4214	8706	18	14346	6099	8247	27	14831	6859	7972	11	12589	4804	7785	2	27590	12946	14644				
Living in communities of 10,000 to 25,000					5	10101	3433	6668	12	19021	4826	14195	12	12933	5742	7191	4	17421	6452	10969								
Living in communities of over 25,000	1	5000		5000	14	12988	2730	10258	25	13765	3040	10725	33	18067	5179	12888	12	17532	4770	12762	5	23240	4531	18709	5	16144	4358	11786
Living in Milwaukee County	3	3926	1073	2853	9	6163	1585	4578	21	16748	6715	10033	27	22692	7413	15279	6	18931	7028	11903	1	28498	837	27661	2	15673	3501	12172
Average Income of Specialists Other Than Surgeons:																												
Living in communities of less than 2,000													1	18973	8709	10264									2	9301	5192	4109
Living in communities of 2,000 to 10,000	5	6985	2304	4681	6	7696	2244	5452	14	11360	4685	6675	19	10069	3869	6200	5	15391	3587	11804	2	10347	2680	7667	1	11414	5276	6138
Living in communities of 10,000 to 25,000	2	3619	770	2849	4	6863	2266	4597	9	11906	4613	7293	9	11078	4360	6718	5	11355	4229	7126					4	13676	4345	9331
Living in communities of over 25,000	2	4145	661	3484	23	12608	3896	8712	41	14023	4109	9914	33	12321	4748	7573	12	12982	4541	8441	1	11410	9135	2275				
Living in Milwaukee County	4	4897	1970	2927	31	8976	2936	6040	61	11765	3952	7813	52	16652	6346	10306	14	15102	7556	7456	9	16329	7149	9180	7	21560	12746	8814

This table is inserted to serve the *sole* purpose of giving some light to the question of relative incomes according to years in practice. Its use by the reader should be restricted accordingly. Its inaccuracies for the purpose of drawing any other conclusions will be obvious to all for it averages the $70,000 a year man with the $1,000 income earner and it has averages based on too few incomes.

Estimates of Totals

Our best estimate would be that the total *gross* income of this group of 707 would be in the neighborhood of $3,000,000.

The total *gross* income for the 2,129 physicians of our study, for the year 1930, was $16,112,868. The total *net* income amounted to $10,014,145. The total *gross* income of all physicians (2,836) in Wisconsin for 1930 is estimated at $19,000,000.

The total *gross* income for the 291 in our study who derived at least the major portion of their income from surgery was $4,578,686. The total *net* income was $2,699,162.

The total *gross* income for the 378 specialists (other than surgeons) was $3,762,433, and the total *net* income amounted to $3,015,613.

The total *gross* income for the 1,460 general practitioners amounted to $7,771,749, and the total *net* income $4,299,370.

Of the 2,129 physicians in our study, 69% derived their income from general practice, 14% principally from surgery and 17% principally from specialties other than surgery.

Averages

While a study of 2,129 physicians' incomes in this state covers 75% of the physicians, it would be misleading to attempt averages on the basis of the relatively small number of returns in any one group within the study. Many questions arise and are of interest concerning averages for the several classifications. These are best answered, however, by printing detailed tables for the two years in practice groups in which we find the majority of our returns,—10–19 and 20–29. These tables follow:

GENERAL PRACTITIONERS

1930 Net Income **10–29 Years in Practice**

Size of Community

	0 to 2000	2 to 10,000	10 to 25,000	Over 25,000	Milw. Co.
$1,000— 1,500	27	9	2	7	21
$1,500— 2,000	31	9	6	5	24
$2,000— 2,500	*27**	20	5	18	27
$2,500— 3,000	28	13	3	15	*17**
$3,000— 3,500	30	*12**	*5**	*7**	13
$3,500— 4,000	15	13	3	10	15
$4,000— 4,500	13	7	2	8	5
$4,500— 5,000	9	9	3	4	14
$5,000— 6,000	7	10	4	9	17
$6,000— 7,000	7	4	1	9	8
$7,000— 8,000	3	5	1	7	8
$8,000— 9,000	------	4	1	------	2
$9,000—10,000	------	------	------	2	2
	197	115	36	101	178
Less than $1,000	24	10	5	13	26
Over $10,000	------	1	------	1	10

*Indicates median average excluding those under $1,000 and over $10,000.

SURGEONS AND SPECIALISTS

1930 Net Income **10–29 Years in Practice**

Size of Community

	0 to 2,000	2 to 10,000	10 to 25,000	Over 25,000	Milw. Co.
$1,000— 1,500	------	------	------	------	3
$1,500— 2,000	------	------	2	2	2
$2,000— 2,500	------	------	------	1	5
$2,500— 3,000	------	3	1	------	14
$3,000— 3,500	------	4	------	5	6
$3,500— 4,000	------	6	7	6	5
$4,000— 4,500	------	4	2	3	5
$4,500— 5,000	2	6	------	10	15
$5,000— 6,000	------	5	3	16	9
$6,000— 7,000	*7**	*9**	*9**	*13**	*12**
$7,000— 8,000	2	9	1	7	10
$8,000— 9,000	1	8	5	13	15
$9,000—10,000	------	7	6	8	8
$10,000—11,000	3	3	2	5	11
$11,000—12,000	------	5	------	1	7
$12,000—13,000	------	1	1	8	6
$13,000—14,000	------	3	2	6	5
$14,000—15,000	------	------	------	2	2
$15,000—16,000	------	------	------	4	1
$16,000—17,000	------	------	------	3	5
$17,000—18,000	------	1	1	3	3
$18,000—19,000	------	------	------	2	4
$19,000—20,000	------	1	------	1	1
	15	75	42	119	154
Less than $1,000	------	1	------	------	7
Over $20,000	------	------	2	12	18

*Indicates median average excluding those under $1,000 and over $20,000.

The question naturally arises as to what should be the return for a physician on his investment in education and equipment. We do not feel qualified to make such a study and have referred this question to the American Medical Association. The Association advises us that even though they have a large amount of data on the subject, they are not in position to give any authoritative statement. It will be made known to us as soon as it is available.

NET INCOMES OF ALL PHYSICIANS IN 1930

Receiving less than $2,000 *net*	26.3%
Receiving less than $2,500 *net*	35.5%
Receiving less than $3,000 *net*	43.8%
Receiving less than $4,000 *net*	57.9%
Receiving less than $5,000 *net*	68.0%
Receiving *over* $5,000 *net*	32.0%

Decrease in 1931

Using average groups of representative physicians in populous and rural sections, a partial check was made to throw some light on the decrease in incomes in 1931 over those of 1930 here reported. We

were particularly concerned with the general practitioner and such study seems to indicate that the decrease was 6 to 7% in the cities and somewhat higher in the rural areas running as high as 12%. This check was made only in selected counties and does not represent the accuracy of a complete study throughout the state.

Possible Economies

From our studies of expenses we are led to suggest to physicians that where possible and feasible they make such consolidation as will promote economy through the joint use of office space, assistants and expensive apparatus that finds rather infrequent use in any individual office.

Where office space is available to all practitioners of a community on the first floor of a community hospital we are in accord with the suggested use of hospitals for such purpose as a means of revenue to the hospital, economy to the physician and convenience and economy to the patient.

Free Service by Individual Physicians in Private Practice

Free service by individual physicians falls into four classifications:

A. Charity service given knowingly and for which no charge is entered upon the books. This includes free service by non-paid staff members of public charitable institutions.

B. Charity given through charging far less than what is the usually accepted minimum fee, again given knowingly.

C. Enforced charity by reason of inability to collect charges entered.

D. Enforced charity by reason of being called to care for one discovered to be indigent but for whom authorities preemptorily refuse authorization for care at the expense of tax funds.

A. and B. Charity given knowingly appears to average ten per cent of the gross cash income if figured on an average fee basis. Studies by the Medical Society of Milwaukee County would indicate a higher percentage but we believe our percentage for the state to be nearly accurate. For the state at large this amount, predicated on our income studies and estimates, would be $1,900,000 for the year 1930.

C. Percentage of medical fees not collected. The Bureau of Medical Economics of the American Medical Association made a study of income reports for 1928 of 6,238 physicians in the United States. This study includes reports from physicians who limit themselves to a particular type of special practice as well as those in general practice.

It was found that 129 questionnaires were returned by Wisconsin physicians. Of these, 17 physicians' incomes were derived wholly, or in large part, from salary, or otherwise were not useful for our Wisconsin study. The total gross income for the 112 Wisconsin physicians amounted to $1,199,761. The total net expense was given as $415,463, and the total net as $784,298. The estimated average per cent of collection for the 112 physicians was 80.6%.

These figures appear to check with our independent studies and accepted would indicate on the basis of our 1930 income study the value of such services to have been $4,570,000.

D. It is exceedingly difficult to obtain definite information in this classification. Studies in Polk County where accurate data is available indicates that prior to the adoption of a county contract the physicians lost on an average of $300 each in the year of 1929.

These estimates (excluding D, above) would indicate a total of $6,370,000 for the year 1930.

In a survey of 181 physicians in St. Louis (Journal of the Missouri Medical Association, March, 1932) the value of charity work averaged $2,145 for each physician. In the report of the Public Relations Committee, Kent County Medical Society, Michigan, April 1932, the charity work of 140 physicians was figured to average $4,587 per physician. Our estimate of the Wisconsin situation is between the two with an average per physician of $2,246.

It is to be noted that in our recommendations in the concluding pages of this report we are suggesting means of securing a more nearly proper basis for making a revised estimate in the late fall. We appreciate that this is a difficult situation in which to arrive at accurate data but for the present we are inclined to believe that our total of $6,370,000 is not far from the actual condition.

It will at once be appreciated that here is an astounding gift to the public in a field where it has well been said that the responsibility for the larger part of this total is one that belongs to the entire public.

Incidence of Illness

The Committee on Cost of Medical Care reports that the best data available to it suggests that only 2% of the population are sick at any given time. The Committee states that men will average 1 illness per year, women 2 per year and in children the average is somewhat over 2. It is of particular interest here to recall that the Commission on Medical Education asserts that 90% of all illness can be treated by the general practitioner and that but 10% require hospitalization and the service of specialists.

Our interest is engaged, however, not only in *how many* are sick but what *proportion* of the sick bear the heavy costs of *sustained* illness. On the basis of what appears to be the most recent study* the following data is obtained:

STUDY FROM 22,172 CASES OF ILLNESS

1. 66.1% ill for 3 days or less. 33.9% over 3 days.
2. 80 % ill for 7 days or less. 20 % over 7 days.
3. 92.5% ill for 14 days or less. 7.5% over 14 days.
4. 95 % ill for 4 weeks or less. 5 % over 4 weeks.
5. 97.9% ill for 8 weeks or less. 2.1% over 8 weeks.
6. 98.9% ill for 12 weeks or less. 1.1% over 12 weeks.

Assuming an average Wisconsin family of four and assuming they had these average illnesses we thus would have one illness for the husband, two for the wife and perhaps five for the two children—a total of eight for the year. It is apparent from previous figures that the chance of extended illness is not large but in such event, particularly if duplicated in a given year in a given family, the costs may be very high to the family that is so unfortunate.

The Wisconsin State Board of Health believes that the incidence if illness in Wisconsin approximates that in Massachusetts where it was found that approximately one-fourth of the people over forty complained of some chronic illness, one-third of which were not under the care of a physician. In 1930 Wisconsin had a total of 923,830 persons over forty years of age. Assuming that one-fourth of this group to have been afflicted with some chronic illness, we would have 230,957 or eighty-one persons per physician if all were under medical care. If, as in Massachusetts, only two-thirds of this group were receiving medical attention this would indicate that the average physician had fifty-four patients whom he was seeing from time to time for some chronic complaint.

In Massachusetts approximately three and three-fourths percent of the population were afflicted with some form and some degree of so-called rheumatism, the most frequent of the chronic complaints. If this percentage were carried into Wisconsin, as the State Board of Health believes proper, we would have 110,212 of such cases or nearly one-half of all cases of chronic disease.

"If health conditions found in Massachusetts were applied in Wisconsin, as we believe proper," declares the State Board of Health, "we are paying a tremendous price in actual costs of illness and loss of wages for chronic afflictions, at least one-half of which could be avoided by annual physical examinations started in early life, and the cultivation of habits of right living."

It should be kept in mind, however, that if death rates may be used as an index to illness, Wisconsin as a healthy state is a leader in the Union. The present statement is thus to be considered only as indicating where future advance may take place.

Expenditures for Medical Care

From the work of the Committee on the Costs of Medical Care we learn that in Franklin County, Vermont 3% of the expendible income of the family went for medical care. This percentage was slightly under 4½% in Shelby County, Indiana, slightly under 3% in San Joaquin County, California and somewhat in excess of 4% in Philadelphia, Pennsylvania. It is to be kept in mind, however, that these percentages represent averages.

* Edison Electric, 5 years ending Dec. 31, 1928, p. 65. Study 2, Committee on Costs of Medical Care.

A table showing the distribution of these per capita expenditures for health follows:

	Franklin County $21.20 per capita	Shelby County $21.32
Physicians	$6.61—31.2%	$7.18—33.7%
Drugs and Medicines	5.76—27.2%	6.34—29.8%
Hospitals	3.86—18.2%	3.14—14.7%
Dentists	1.57— 7.4%	2.19—10.3%
Public Health	.50— 2.4%	.28— 1.3%
*All Other Services	2.90—13.6%	2.19—10.2%

	San Joaquin County $36.09	Philadelphia $53.89
Physicians	$8.68—24.1%	$14.12—26.2%
Drugs and Medicines	6.75—18.7%	10.96—20.4%
Hospitals	8.48—23.5%	15.53—28.7%
Dentists	5.76—16.0%	6.81—12.6%
Public Health	1.24— 3.4%	1.36— 2.6%
*All Other Services	5.18—14.3%	5.11— 9.5%

* Nurses, other practitioners, supplies, etc.

The thoughtful man must be in at least partial accord with Professor Lapp when he said:*

"The problem is perfectly clear. It is not one of the cost of medicine. The cost of medicine is not a real factor in providing medical service for the masses of the people of this country, despite the two or three million dollars that the Committee on the Cost of Medical Care is spending to find out the facts. It does not make any difference how much medical service costs. However much it costs, it is worth it. It is worth many times the cost of medical services last year that one million people did not die, and that 250,000 babies did not die.

"Moreover, the total cost of medical care is really inconsequential when viewed socially for the masses of people. Furthermore, let me say, and I am quite sure you will agree with me, that the cost of medical care cannot be very materially reduced. When anybody proposes the idea some way or other, by some hocus-pocus, the costs are going to be reduced, I think always in the terms of advancement of medical science; the new requirements for equipment; the vast institutions we must have in the form of hospitals and the investment in technical equipment we must find therein. I believe the cost of medical care is going to increase despite all the movements that organized medicine can make. The cost of medical care is going to increase, and as a matter of fact I hope we shall spend twice as much for medical care as we do now. We will spend twice as much for medical care when all the people of this land have the kind of medical service they ought to have within their capacity to pay.

* John A. Lapp, Director, Department of Social Science, Marquette University, before Secretaries' Conference, State Medical Society of Wisconsin, 1931.

"Gentlemen, the people who are talking about the cost of medical care are barking up the wrong tree. It is not the cost of medical care. It is the distribution of the cost of medical care. It is not the aggregate cost of medicine that troubles us socially. It is the fact that the cost of medical care falls upon people unevenly, falls upon the weaker portion of the population and falls upon them when they are least able to pay the bills.

* * *

"We are altogether misled, I think, on this question of distribution, because we think there are three classes of people, the poor, the middle class, and the rich. As the statement has been made hundreds of times, the poor get all the medical service they need. The rich can buy all the medical service they need, but it is the great middle class that does not get the medical service it needs. It is a mistake to classify people from this point of view in respect to the poor, the middle class, and the rich.

"Gentlemen, I am poor, I am a charity case if the sickness which happens to afflict me becomes the sickness that is going to last a year or two years, requiring continuous medical and surgical attention. I am a charity case under those circumstances and every other man in similar circumstances is likewise a charity case, because I cannot buy the kind of medical service I need within my income, even though it is sufficient for any normal happening. So you have, you see, not the poor, the middle class, and the rich. You have the people who must have some distribution of their medical burden all the way up from the poor to the fairly well-to-do classes of society. There are very few people who can stand economically the continued burden of a year or two years recurrent sickness with all the costs that go with it.

"Certainly the doctors of this country are not making too much money. Certainly the hospitals cannot be run for less than they are being run. It is because we allow the burden of sickness and sickness costs to fall upon a very few people, and, again, to repeat, upon those people when they are least able to stand it. The burden comes back upon you, the physician, or the public because all the people must be cared for in sickness."

Wilbur's Statement

The contention of Professor Lapp is substantiated by Dr. Ray Lyman Wilbur, Secretary of the Interior and Chairmen of the National Committee on the Costs of Medical Care. In an address before the Milbank Memorial Fund, March 17, 1932, Dr. Wilbur said in part:

> "Among 4,560 families who kept records of their medical charges during a year, we found a wide range of charges per family. There were 1,788 of these families whose total annual incomes for the year were under $2,000 per family. Forty per cent of these low income families incurred medical costs for the entire family of less than $25 for the year, 20 per cent had charges from $25 to $50, 21 per cent from $50 to $100, 14 per cent $100 to $250, 4 per cent $250 to $500, 1 per cent $500 to $1,000, and 0.2 of 1 per cent $1,000 to $2,500. Eighty-one per cent of this group had bills of less than $100 for the year, and, we may assume, could pay their medical charges without serious hardship, but the remaining 19 per cent must impair their living standards, draw on savings or borrow money if they are to meet their expenses. The 81 per cent paid only 36 per cent of the total bill of the entire group, while the 19 per cent were faced with 64 per cent of the amount, making the average per family eight times as high in the latter group.
>
> "No well informed student of medical economics believes for a moment that the patient's difficulty in paying medical costs is primarily or basically due to excessive fees on the part of physicians and other practitioners. There are a few "gougers" in medicine, of course, just as there are in all walks of life, but any impartial analysis of the incomes of physicians leads to the conclusion that in view of the time devoted to training and education, and the responsibilities assumed, there is no general overpayment of practitioners.
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> * * *
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> "If we can act with courage and vigor at the right moment, we will, I am convinced, be able to inaugurate various improved methods of providing medical care to the American people. We neither desire nor expect a mushroom growth but we do wish to make available as rapidly as possible more adequate medical service to a larger number of our people. No other course of action holds greater promise of enriching American life and benefiting every phase of our national welfare."

Care of the Indigent

The Committee on Public Policy of your Society has published during the current year a comprehensive summary of the poor laws of the state as relates to care of the indigent sick. Effective in all counties except Milwaukee where separate system and institutions exist, it must be apparent to the reader that our poor relief laws all too frequently fail in practice to provide that degree of medical and surgical care which is both humane and indicated by good public policy.

For the areas that do not include large cities we believe that the so-called Iowa plan as presently in force for a second year in Polk county, Wisconsin appears to offer substantial advantages over individual authorizations for care of the poor as outlined in our present laws. We believe that modifications of the plan may prove beneficial to profession and public alike in the larger cities.

The outstanding feature of the so-called Iowa plan is, of course, a prior agreement between physician and county officials as to the extent and total cost

of medical relief during the year which has as its effect a more prompt authorization for care in the emergency case and in the Polk county experiment, a somewhat better degree of compensation for the physician encouraging the application of prompt and efficient measures for relief of the sick.

We appreciate that some other states have gone far to perfect their laws which relate to medical relief for the indigent sick. We are continuing our studies with the belief that the near future will enable us to bring to your attention ways and means more suited to meet this outstanding public need.

We are cognizant of the fact that many counties employ a so-called "county physician". In a study of the work of the county physician in some 30 counties we found that in the case of 20, the work of the county physician was limited to the care of the sick and injured in one or more of the county institutions. This appears to be a proper function of the county physician.

In ten counties in our study the county physician presumably was to care for all of the indigent sick within the county. This is obviously a physical impossibility. The revenue to the physician is inadequate and in one instance the physician employed for $1,000 was not only expected to care for all of the indigent sick but contracted to furnish all medicines and supplies as well.

Such a plan is not, in our opinion, conducive to either the securing of proper medical advice or actual care for those who happened to be removed many miles from the city in which the county physician is located.

We find further that at least some cities attempt to operate on a similar plan. Again it is the belief of your Committee from studies available to us that the services of a single physician to care for the indigent on a contract basis leads to a competitive bidding or selection upon political basis, generally at an inadequate return not commensurate with the services that every community should desire to make available to the indigent sick. Such a plan is neither humane or in the interest of sound economy.

Under the present laws where relief is administered upon the basis of prior authorization by a town or county officer, it is our finding that it is frequently impossible to secure such authorizations by reason of (a) physical impossibility to reach officer in rural sections by reason of no telephone, (b) proper official out of county, (c) reluctance to add to the obligations of the town or county, and (d) failure to understand or appreciate the intent and plain wording of the law.

Obviously the patient in emergency cases requires immediate care. At present we find that the cost of such care is all too frequently bourne by the physician and hospital with the net result that it increases the cost of care to the pay patient. Physicians will always give charity willingly but it seems to your Committee that their charity might better be given those who are striving to maintain an independent status rather than to the wholly indigent who must be the concern of the entire government unit.

In addressing the Committee on Public Relations of the Kent County Medical Society, Michigan (1932), Dr. James Wallace of the American Public Health Association declared:

> "With the great increase in demand for such services due to unemployment, many places have been at their wits end to know what to do. The greatest problem at the present time is to arrange for some reasonable compensation for the physicians who do the work."

We also call attention to the following communications to the same point:

> Dr. B. W. Caldwell, executive secretary of the American Hospital Association, writes as follows: "You are advised that all plans for the relief of the unemployed which have come to our attention—including the White House plan—have been singularly free from any provision for the medical or hospital care of the indigent sick.
>
> "Naturally the medical profession, especially those who are on the staffs of our hospitals, are giving their services and frequently their money to the same good cause. The American Hospital Association is on record and it is gratifying to know that this policy is being viewed with increased favor that:
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> " 'The care of the indigent patient who has to have hospital and medical care is the responsibility of the organized political divisions, such as states, counties, cities and the federal government.'
>
> "If the different political divisions would remunerate hospitals, whether tax-supported or philanthropy-supported, by a remuneration equal to at least the cost of maintaining the indigent sick in the hospital and at the same time pay the attending physician who attends them a proportionate fee, there would be no failures of hospital operation in this country and the medical profession would receive in part an income which it has unquestionably earned."

Surgeon-General, H. S. Cumming, writes as follows:

> "I know of no group in this country who have suffered more from the present conditions or who have contributed as much to relief as the medical profession. In the various community chests and other funds for relief which have been raised in many communities the welfare and social worker and others have been provided for but I know of none in which compensation for physicians has been included, and although unquestionably the traditional altruism of the profession still holds with the majority of its members there is a limit beyond which they cannot go, for they must maintain their families and professional equipment."

In our own state Dr. C. R. Bardeen, Dean of the Medical School of the University of Wisconsin, declared as early as 1929:

> "Many people not indigent in the usual sense of the term have not funds or credit sufficient to pay for care involving expensive equipment and service. Such people are apt to be far more deserving of aid when ill than are many of the 'down and outers' and the public is much more apt to profit in the long run from the aid thus given than from charity to paupers."

This is the precise contention of the Committee,—that the cost of adequate and competent medical service to indigents is a civic responsibility. Just in the proportion that it must be continued by physicians as individual charity, just in that degree is the physician unable to extend it to those who in our estimation are the more deserving,—those who are trying desperately to maintain their independent economic status. If we will thus recognize that the charitable work which will ever characterize the profession of medicine has some limitation in extent then we will appreciate that the basic and fundamental question is not a limitation but rather a proper direction and application of this great gift. If it is to be continued in large percentage to those whom Dean Bardeen characterizes as the 'down and outers' who are the real responsibility of the community, by just that extent it loads the cost of medical care on the sick who are endeavoring to pay their way. So does it follow that the assumption by the community of their responsibility in caring for the indigent will affect a better distribution of the costs of illness and relieve the physician and the hospitals of a burden that is not theirs and the assumption of which can only militate against the very distribution of costs to which end we are so vitally interested.

Contract Practice

Contract practice presents somewhat different phases dependent upon the character and size of the community in which it is found. Recognizing that its phases are most complex in the metropolitan area, your Committee welcomed the cordial cooperation of the Medical Society of Milwaukee County and the survey of this subject made in that area is being made by a committee of this component society under plans approved by your State Committee and on an approval made by us.

Coincident with this study we are making similar studies in two other types of counties. It is our hope that the combined report may be ready in part, at least, for presentation on the floor of the House.

Miscellaneous

Your Committee has attempted to make at least preliminary studies of the work of the non-official lay organizations and of those state agencies that at least supplement the work of the physician. Since the appointment of the Committee, however, the Council has appointed separate committees to deal with so much of this field as relates to the Wisconsin General Hospital and the Wisconsin Anti-Tuberculosis Association.

In event the House sees fit to continue the work of this Committee we will correlate and extend the findings of these committees with further studies on those not covered. For the present it does not seem fitting that your Committee endeavor to make studies separately where very similar ones are already in process. From our observations, however, we will make partial recommendations and suggestions in the conclusions of the report.

Recommendations

In view of the study that has been made and the data compiled your Committee submits the following recommendations at this time:

1. That the Committee be continued to the 1933 meeting of the House of Delegates with such appropriations from the Council as will enable it to complete its studies so far as further effort shall seem desirable.

2. Care of the indigent:

   a. We recommend that the Society disapprove any system which provides a single practitioner to care for the indigent, except such as may be in institutions, for the reason that such a system is not conducive to securing a proper public service.

   b. We recommend that each component Society investigate in the light of its own peculiar requirements, those plans and suggestions advanced to provide a better service for the indigent sick. In this investigative work we shall continue our own efforts and pledge to the several counties our cordial cooperation.

3. *We recommend to the Society that it enunciate the principle that the care of the indigent is a community obligation;* that the physician should receive a reasonable compensation therefore, and that the charitable work that will always characterize the profession of medicine should be continued to that class of individuals who are endeavoring, under great handicaps, to maintain their independent financial status.

4. In such organizations as may employ a fiscal agent for the purposes of assessment and collection of fees, our attention is called to the fact that such individuals frequently are the products of commercial schools and sometimes are primarily interested in a showing of income over expenditures. Such a system, lacking the immediate and personal supervision of a physician, tends to result in fees exorbitant to particular individuals reflecting to the discredit, not only of the group, but of the entire profession. We earnestly recommend that this Society voice the principle that under the conditions cited some physician of the group be selected as an

immediate advisor of the fiscal agent and be consulted in the matter of assessment and collection of all fees.

5. We recommend that all hospitals seeking public support make available their facilities to physicians who live within a reasonable radius in the immediate rural area. Recognizing the responsibility of the hospital to assure its patients of proper care and its reluctance, in some instances, to permit of the practice above suggested we recommend that in event that the practitioner in the rural area is not within easy call that he still be permitted the use of the hospital upon association with a physician resident in the hospital community who will assume responsibility for answering any emergency call. The purpose of this recommendation is to make available to the practitioner adjacent to the larger centers such facilities as will enable him to give a proper care to his patients without depriving himself of the revenue that alone may make it possible for the rural area to enjoy his services. This recommendation is not intended to urge upon hospitals or their staffs any departure from established procedures whose purpose and intent is to limit the staff to those well qualified in the particular services in which they desire to enter patients.

6. The Wisconsin Hospital Association, to the end of protecting the patient from inadequate medical services, suggests that hospitals require membership in the county and state medical society as first prerequisite to admittance of physicians to practice in the hospital. That physician not sufficiently interested to keep abreast with medical progress should not benefit by those facilities that have been erected by a forward looking community for the competent men and whose use in the hands of the incompetent will serve only to give the patient a false and misleading sense of security. We endorse this principle with the request, if this be adopted by the House of Delegates, that each delegate bring to the 1933 session a report on this subject matter as affects hospitals within his area and their then present procedure in this respect. Application of this principle should not operate to deprive a non-member who appears to have proper qualifications from enjoying a probationary status pending action by the County Society upon his prompt application for membership.

7. From our studies of hospital costs*, numbers of hospitals and occupancy we are of the opinion that the costs of illness are unnecessarily increased by duplication of hospitals beyond requirements within a given community, by too large a proportion of building costs being devoted to pleasant but unessential items, and by managements that do not include at least one representative of the medical staff on the boards of trustees.

We recommend that the component societies interest themselves in this situation with sufficient activity to the end that:

a. No new hospital is built with the support of the profession unless it is clearly needed.
b. In event additional beds are required that it be pointed out that it is more economical to add to existing hospitals than to construct new and competing institutions with the duplication of overhead.
c. That the board of directors of each institution include at least one representative of the medical staff.
d. In event that a hospital is to be constructed from funds raised at least in part by public subscription, that the fund be set at a sufficient amount to include a substantial endowment for the, possibly unanticipated but certain, future financial needs of the institution.

8. We believe that the findings of the Commission on Medical Education that the family physician will always be the most economic and satisfactory physician for 90% of human ailments are sound. We recognize that the costs of illness may be unnecessarily increased by a public demand for non-essential services. We believe that physicians owe a duty to their patients which should comprehend at all times advice as to the exact needs of the patient and that this principle should apply equally and impartially to provide for a high degree of skill and care or to limit those procedures which will build up costs out of all proportion to the essential requirements for restoration of health.

9. From our studies and those of the Committee on Costs of Medical Care it is evident that the public itself is responsible for a considerable proportion of present costs of illness through the purchase of ill advised and worse than useless remedies and the services of the improperly or wholly uneducated. That self diagnosis by the individual which leads him to purchase drugs on the basis of extravagant advertising claims of the manufacturer and without competent advice, is a pure economic extravagance which so frequently brings to our attention the tragic result of a disease far progressed which might have been controlled when the individual first sought a cheap relief. We mention this here only to point out that the greatest cost of self diagnosis, the purchase of useless and sometimes dangerous drugs or the purchase of the services of the uneducated is not the monetary waste but the time that is lost.

10. To those essentially rural communities which are unable to secure resident medical service by reason of inadequate income for the practitioner, we commend as an experiment the plan advanced by the State Health Officer of paying such resident physician a reasonable base income as Health Officer. The family physician is ever the first line of defense and offense in all public health endeavor and such suggestion is made wholly in the interest of conservation of health and of better medical service.

11. That we may have still more accurate data on the charity services given by the profession we recommend that this Committee be authorized to prepare a special schedule to be used by every member for the purpose of recording such amounts

* Wisconsin Medical Journal, June, 1932, p. 418, ff.

during the month of November 15th to December 15th next, and that the membership be urged by the House to give of this study their faithful and careful aid. An appropriation of $200 is requested for this purpose.

12. We recommend that the several constituent societies interest themselves in the subjects of examinations for the pre-school child, examinations of school children, and such projects as protection against smallpox and diphtheria that these services may be made available to every child in Wisconsin, by such arrangements as will provide these health services at a reasonable cost within the means of each individual parent to meet.

13. Except in times of epidemics we do not favor administration of toxin-antitoxin or vaccination by health departments from tax funds until such time as it can be shown that a campaign by the health department to educate parents who can afford such procedures to take advantage of this essential protection for their children, has failed of accomplishment. We assert that such services in the field of prevention as are practiced upon the individual are well within the field of the general practitioner who must receive the modest income this field permits if he is to continue.

In enunciating this principle for adoption by the House, your Committee is mindful of the work of Dr. Henry F. Vaughan, Commissioner of Health for the city of Detroit. In his address before the Health Officers Section of the American Public Health Association*, Dr. Vaughan, speaking out of long experience which comprehended a careful trial of all methods for the public protection, committeed himself to the proposal above.

> "If we agree," said Dr. Vaughan, "that the goal toward which we are aiming is universal participation in procedures of preventive medicine and health promotion, then some group or groups of individuals must be prepared and ready to meet the demand for service which this goal would entail. To put it more simply, if we expect all persons, young and old, to do the things which we think they should to prevent disease and maintain good health, the services indicated will have to be supplied by some group or groups of individuals. It is our contention that it is unreasonable to expect any large reasonably well-to-do community itself to supply sufficient funds and personnel to provide all the services necessary to insure universal participation in the field of preventive medicine and health promotion. From whom then can these services be obtained, except from the private physician, dentist, nutritionist, psychiatrist, etc.? If these hypotheses are well founded the official health organization has two important functions to perform.
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> 1. To create a demand on the part of the people of the community for well proven scientific procedures of preventive medicine and health promotion.
> 2. So to cooperate with the medical and dental professions that the services will be adequately provided when the demand arrives. This means in effect that the health organization must take the message of preventive medicine and health promotion to the practicing physician and dentist to the end that they may become better able, willing and anxious to participate in this type of work."
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> "To summarize very briefly, it is our opinion that the program of having the private practitioners of medicine give diphtheria prevention treatments has a number of distinct advantages over the method of having this work done in schools or clinics.
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> 1. The policy is in keeping with the average American's desire to choose his own grocer, his own clothing and his own physician.
> 2. It tends to place the responsibility, for that particular phase of child health at least, in the hands of the parent where we believe it rightfully belongs.
> 3. It makes a substantial beginning in attaining the goal toward which we are aiming: a greater degree of participation on the part of the private practitioner of medicine and health promotion.
> 4. It has a cumulative educational effect on both patient and physician which does not obtain in the clinic system. For example, if in the immunization of 50,000 children by private physicians we have created even as few as 2,000 new contacts between family and physician, which contacts become enduring, and the physician becomes the family health adviser, we will have accomplished something of far more reaching effect than the immunization of 50,000 children against diphtheria, important as that is.
> 5. This system seems to result in the immunization of a larger percentage of the most susceptible group, the preschool child."

14. With respect to free diagnostic clinics not exclusively for the indigent, we suggest that findings of the examiner be forwarded to the family physician from whom the patient shall learn of his condition. The purpose of this recommendation is to provide opportunity for a correlation of present findings with the patient's past history to afford a far better basis for suggestions as to future procedures, and to bring the patient into contact with his family physician who presumably will take the occasion to

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* American Journal of Public Health, July, 1931, pp. 751 ff.

urge immediate action to correct remedial defects, the neglect of which may lead to serious conditions.

15. We recognize that where the general practitioner refers cases to specialists who reside outside of the home city of the patient, such specialists have little opportunity to learn of the financial obligations and status of the patient. We recommend that referring physicians be encouraged to send to such specialists, under such conditions, letters advising of the patient's present financial status and outstanding obligations. Such a procedure on the part of the referring physician should be as commonplace and essential as the forwarding of the complete and accurate case history. This suggestion does not contemplate any procedure that in any manner affects the present relationship of physicians under that portion of the Principle of Medical Ethics which relates to "Commissions". Our sole motive is better to secure for the patient an equitable financial arrangement and for the referring physician, a better opportunity to collect for himself his fee for valuable diagnostic services.

16. Medical Service Abroad. Earnestly desirous of affording a good scientific service to the residents of this state at a cost within their means to meet, we are appreciative of the desirability of such procedures as will effect a distribution of costs without impairment of the service. Aside from those procedures herein outlined to accomplish in part such distribution, we are sincerely of the conviction from our studies that such systems as may exist in other countries have been purchased by the great sacrifice of a good service for a poor service. Poor medicine always has been, and always will be, far more expensive to the community and the individual. A standardized mediocrity in the care of the sick is abhorent to the minds of all physicians. The principle fault we find with all plans to which we have given our close attention is that they are the means of the purchase of a cheapened service rather than the distribution of costs for a good service. Their present adoption in Wisconsin could only work a great and irrevocable injury to the sick and injured.

For the present we urge upon you those suggestions advanced in this report and upon the public a recognition of the fact that illness is as inevitable as death and that savings must be made in anticipation of both.

17. Appreciative that the years immediately to come will bring forth numerous and varied proposals looking to a better distribution of the costs of illness, we would take this occasion to counsel against such haste to solve a difficult problem as so frequently entails disaster as the end result. By the creation of this committee you have evidenced your desire to be forward looking in the interest of the public and profession. We urge upon you, however, that as individual practitioners and as component societies your efforts be confined to those approved procedures of tested value.

Conclusion

We are in the midst of a period of great economic stress. Some 33% of our normal earners in this state (excluding farmers) have no work and no income. Another 17% are making a precarious living on the basis of part time work. Physicians are seriously affected but not in such proportion nor to such extent. So do we counsel against the institution of any proposal susceptible of any interpretation that this Society is interested primarily in financial gain for its members at the expense of the public interest. We have never been so interested nor are we now. We reaffirm as our purpose that section of our Constitution which says that we shall "enlighten and direct public opinion in regard to the great problems of state medicine, so that the profession shall become more capable and honorable within itself, and more useful to the public, in the prevention and cure of disease, and in prolonging and adding comfort to life."

The economic stress of the present may be more acute than at any prior period but it is not new. Sixty-one years ago the profession of Wisconsin was confronted with trials and tribulations as it has ever been confronted. In the annual President's Address before our society on June 22, 1871, Dr. H. B. Strong concluded with a statement that rings so true that we commend it to the profession today.

"Medicine is, at present, in the midst of one of these transitions," declared Dr. Strong, "and I would have you act honestly and intelligently. The skillful climber holds fast to the present support until he has made sure of his grasp upon the round above, and we, if we would come out of the present transition period of medical practice, at a point above that of our entrance or actual position, must resist the tendency to dishonesty and to extreme views—taking a maxim from a book of the highest authority, 'prove all things; hold fast that which is good.'

"The danger in transition periods lies in the tendency of the human mind to oscillate to extremes. Tired with familiar exercises and results, captivated by novelties, intoxicated by the inspirations of hope, we rush forward to positions which sober experience proves to be untenable, and in disheartening retreat, lose spirit and courage, as well as the actual fruits we might have secured by more patient and conservative labor. The great problem at such times, should be the fusion or amalgamation of the great elements of all existence, stability and progress—the great desideratum, fidelity to our inheritances from the past, and a cordial welcome to the invitations of the future."

Supplemental Report of the Special Committee on the Distribution of Medical Services in Wisconsin

Contract and Panel Practice

To the 1932 House of Delegates:

Recognizing that any survey of medical services in Wisconsin must necessarily include a study of contract and panel practice, your State committee allotted a substantial portion of its funds to a special committee of the Medical Society of Milwaukee County for the purpose of making such a study in that metropolitan area. During the period of this study, your committee made similar studies in Rock and Polk counties, the first a part rural and part urban area and the second county practically an entirely rural area. Our findings in these two counties are to the effect that contract practice exists in exact proportion to the size of the urban areas and does not differ, except as to degree, from that found in the metropolitan area of Milwaukee.

Your committee submits herewith the report of the findings in Milwaukee County. We feel that the study has been made with great care and is deserving of your very careful and thoughtful attention. The data obtained from the studies in Rock and Polk counties will be retained in the Society office.

Recommendations

We concur in the recommendations of the Milwaukee County study that have state-wide application and specifically emphasize the following:

1. The subject matter of this survey, particularly as it relates to contract practice, is deserving of continued study and we will undertake such efforts in event your House sees fit to continue the Committee another year.

2. We concur in recommendation number three that it is to the mutual best interest of the injured that panels under the Workmen's Compensation Act include all physicians willing and capable of doing compensation insurance work. We suggest that the House of Delegates give the appropriate committee of the State Society specific instructions whether the foregoing objective best may be accomplished by supporting legislative measures providing "free choice of physicians by the patients", or (2) whether it is to be accomplished by contacts with the insurance companies to the end that existing panels may be enlarged.

3. We concur in recommendation number seven that the study discloses the fact that such types of contract practice as in themselves do not provide an adequate fee for the physician and do not guarantee an adequate service to the public are not in the public interest and their continuance can only serve to imperil the interests and lives of the insured.

Respectfully submitted,

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D. E. W. WENSTRAND, M. D.,
GUNNAR GUNDERSEN, M. D.,
OTHO FIEDLER, M. D., *President ex officio,*
J. G. CROWNHART, *Secretary.*

CONTRACT AND PANEL MEDICAL PRACTICE IN MILWAUKEE COUNTY

The type of contract and panel medical practice in any community depends to a large extent on the economic structure of the community and the laws of the state which govern medical practice. It was these facts that impressed upon the officers of The Medical Society of Milwaukee County the necessity for a thorough study of the situation in Milwaukee County, so that any action which eventually might be taken would be based on ascertained facts. In their estimation any other basis for action might lead to grievous errors. In this the Society, at a session held on April 8, 1932, concurred, when in a resolution adopted at that time it directed "its officers to bring promptly and forcefully to its parent organizations, the State Medical Society of Wisconsin and the American Medical Association, its belief and desire that the corporate, contract, and panel practice of medicine should at once be given thorough study and careful consideration."

As the Society is operating on a limited budget, the State Medical Society, which has just completed a state-wide study of the distribution of medical services, through its Special Committee on Distribution of Medical Services, provided the necessary funds for the study in Milwaukee County. Dr. R. G. Leland, Director of the Bureau of Medical Economics of the American Medical Association, also offered his services which were gladly accepted. His help has proven exceedingly valuable to the Social Medicine and Medical Economics Committee of The Medical Society of Milwaukee County under whose direct supervision this study was made.

Aside from the 544 physicians supplying information for this study, 42 corporations replied to communications directed to them in regard to medical services provided by them to their employees. A voluminous correspondence was necessary to obtain information from governmental agencies, business establishments, industrial plants, and sick benefit associations, and a secretary was employed to assist in this work. Considerable difficulty was encountered in determining essential facts about medical services sponsored by lodges and fraternal organizations. An investigator was employed to locate officials of lodges and fraternal organizations, and to secure data for this report. The staff at the executive office of the Society also assisted in the study.

It was estimated that a large number of physicians in Milwaukee County were engaged in either contract or panel practice and there was some skepticism as to the value of the information which might be obtained. In sending out its schedules the Committee sought to impress members of the Society that the study was to be impartial, the results of which would be submitted to all members of the Society for their conclusions. The response was most satisfactory, as this report shows. The majority of those holding contracts or serving on panels manifestly wished all the facts known, and stood ready to give any assistance they could. A very few were of the opinion that the study was not justified, and some were vague in giving information. The medical profession of Milwaukee County is to be highly commended for its support of this study which was difficult to make.

The Committee realizes that the report is not without inaccuracies but believes that these are of a minor nature and in no way affect the value of the study. No effort has been spared to obtain exact information where there was any doubt.

Before presenting facts obtained it may be well to call attention to the differentiation which has been made in this study between contract and panel practice. It was originally intended to make a study of contract practice alone, but further consideration of the subject disclosed the fact that a large number of physicians serving industries, business establishments, sick benefit associations, and other organizations were not under contract but were on a panel. These physicians had no agreement, written or otherwise, insofar as their fees were concerned. Many of them exacted the same fee for their services as they received in their private practices. Any study of medical service sponsored by various organizations and institutions which did not include panel practice would, therefore, be incomplete, and so a section of the schedule sent to members of the Society was devoted to panel practice.

Number of Physicians Participating in Study

At the time of this study the Society had 657 members each of whom received a schedule. Their response is indicated in the schedule which follows:

SCHEDULE A

Physicians Returning Schedules in Study of Contract and Panel Practice in Milwaukee County

Number of members to whom schedules were sent		657
Number of physicians engaged in contract practice	131	
Number of physicians engaged in panel practice	113	
Number of physicians engaged in both contract and panel practice	48	
Number of physicians not engaged in contract or panel practice	252	
Number of physicians reporting	544	544
Number of physicians not reporting		113

It will be observed that of the number reporting more than 50% are engaged in either contract or panel practice; further, that the number engaged in contract practice exceeds those serving on panels. It is the opinion of the Committee, based on its knowledge of the activities of those not reporting, that the proportionate number of those engaged in contract and panel practice would not vary if all members had returned their schedules.

All schedules returned were signed by the reporting physicians.

Concentration of Contract and Panel Practice Analyzed

In this study it was difficult to indicate adequately the extent of the work being done by each member engaged in contract or panel practice. It appeared that some held several contracts or served on more than one panel. A tabulation was made from the returns received (Schedule B) to show how much of

SCHEDULE B

Number of Contracts Held by Reporting Physicians and Number of Panels on Which They Are Serving

Number of Contracts or Panels	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*Indefinite**	*Totals*
Contract Practice										
Physicians in Contract Practice	150	14	11	3	--	--	--	--	1	179
Panel Practice										
Physicians in Panel Practice	64	26	16	2	6	--	1	1	45	161

* Physicians not reporting definite number of contracts held by them or panels on which they are serving.

this work was concentrated among a few physicians. This tabulation is accurate so far as physicians in contract practice are concerned. A number serving on panels did not complete this phase of the schedule, which accounts for the number of those classified under "indefinite." Several stated that they did not know on how many insurance panels they were serving.

Nearly 50% of those in panel practice are serving on more than one panel. Among the "indefinite" group are a number who state that they are on several panels. If facts had been provided by this group the percentage of those who are on more than one panel would undoubtedly be larger.

Fewer physicians in contract practice in proportion to those in panel practice hold more than one contract. As the above schedule indicates there were only 28 physicians out of 179 who held more than one contract. This is apparently due in part to the demands made on the contract physician. Many devote a large part of their time to medical departments of various enterprises, while most panel physicians carry on this practice in their offices. The contract physician also usually agrees to render a general medical service to a specified group, while the panel physician treats only those who are directed to him by insurance companies or insurers. Most panel physicians are rendering service in accordance with provisions of the Wisconsin Workmen's Compensation Act.

Contract Practice

It will be observed in studying the analysis of contract practice in Milwaukee County (Schedule C) that of the 179 reporting contracts, 67 are in the employment of governmental agencies, i. e.,—federal, state, county, and city; and that 62 are engaged by lodges, fraternal organizations, and sick benefit associations. This number accounts for more than two-thirds of the physicians in contract practice in Milwaukee County. A number of sick benefit associations are sponsored by or associated with industries and business establishments, which accounts for the fact that only 14 physicians report holding contracts with industrial plants.

Most of the physicians reporting affiliation with hospitals, sanitariums, and dispensaries are full-time employees who do not engage in private practice. The same is true of those doing life insurance work.

Physicians employed under contract by the county and city are rendering unlimited service direct to the public. Physicians in federal service are employed at the Veterans' Hospital; those of the state, at the Wisconsin Industrial School for Girls and the Wisconsin State Fair. Medical service sponsored by industries, lodges, fraternal organizations, sick benefit associations, some insurance companies, and a miscellaneous group listed under "All Others" is limited to employees or members only. A number, however, include families and dependents.

An important phase of the study of contract practice is the type of medical care rendered. Six physicians engaged in industrial practice report that they treat only injuries, or illness and injuries when employment-connected; 2 treated illness and injury regardless of employment connection; and 6 reported diagnoses only. Lodges, fraternal organizations, and sick benefit associations render much more extensive service. Ten physicians report that they give medical service only, while 48 provide medical and surgical service. It was impossible to indicate in the analysis that among the 48 there is a difference in extent and type of service supplied. Some of these organizations provide only minor surgery and limited medical care, others, unlimited medical and surgical service.

With the exception of those physicians employed by lodges, fraternal organizations, and sick benefit associations, physicians holding contracts are paid by the employer. It will be observed that of the 37 benefit associations, 17 are partly supported by the business establishment or industrial plant with which they are affiliated. In many instances the employer contributes 50% and the employee the other 50% to the funds of the sick benefit association, from which in turn the physician is compensated on a salary or an agreed-sum basis.

One of the questions included in the schedule sent physicians,—which was answered with surprising frankness,—was "Is the compensation derived from your contract practice adequate for the rendering of good medical service based on the usual medical fees paid for the same kind of service and class of people in your community?" The last two columns of Schedule C show that 29 physicians reported "inadequate." Nine of these physicians were employed by governmental agencies; 2 by an insurance company; 18 by lodges, fraternal organizations, and sick benefit associations. It is significant that the majority reporting in the negative held contracts with the latter. Of those who answered this question, 77 were of the opinion that they were adequately compensated, against the 29 replying in the negative.

As a number of the physicians reporting contracts held more than one contract (Schedule B) it was necessary in making this analysis to select the principal contract held by the reporting physician. Often contracts held by one physician were of different types. One physician reported that he held contracts with a sick benefit association, a hospital, and a governmental agency. As his principal contract was with a sick benefit association, it was shown as such in the analysis of contract practice.

Panel Practice

As stated before, most physicians serve on panels required by the Wisconsin Workmen's Compensation Act. The following analysis of panel practice (Schedule D) shows that 94 of the 161 physicians reporting stated that they served on insurance panels. As a matter of fact, all of those reporting with few exceptions,—i. e., federal and county phy-

SCHEDULE C

ANALYSIS OF CONTRACT PRACTICE IN MILWAUKEE COUNTY

Type of Institution or Organization	No. of Physicians Employed*	Service to		Type of Medical Care						By Whom Compensated					Adequacy of Compensat'n	
		Employees or Members only	Employees or Members and Family#	Employment Connected Injuries	Employment Connected Illness and Injuries	Illness and Injury not Employment Connected	Medical Only	Medical and Surgical	Diagnosis Only	Patient	Employer	Employees	Benefit Association	Insurance	Adequate (based on usual fees)	Inadequate
Industry	14	10	4	1	5	2			6		12			2	9	
Governmental Agencies																
a. Federal	5	1				1					5				1	3
b. State	2										2				1	
c. County	28										28				6	3
d. City	32										32				4	3
Lodges and Fraternal Organizations	25	20	5		2		8	14	1	1			24	11	11	11
Benefit Associations	37	21	16				2	34	1		17 part		37		28	7
Hospitals, Sanitariums, and Dispensaries	12										12				6	
Homes for Children and Aged	4						3				4				2	
Insurance	8	3						2	1		5			3	1	2
All Others	12	3		1				2			12				6	
Total Number Reporting	179															

* A number of physicians hold more than one contract. (See Schedule B) Only the principal contract of each physician is used in this analysis.
\# Dependents often included.

sicians, and one reporting as being on the panel of a sanitarium,—were compensated by an insurance carrier or a self-insurer. Several of the larger business institutions carry their own insurance.

Nine physicians stated that they examined applicants for life insurance only, and two physicians made examinations for The Life Extension Institute.

SCHEDULE D

Panel Practice in Milwaukee County

Type of Institution or Organization	Physicians serving on panels*	Compensation (Fee Basis) Adequate (based on usual fees.)	Inadequate
Industry	37	35	--------
Business Establishment	9	8	--------
Governmental Agencies			
a. Federal	1	------	1
b. County	7	5	1
c. City	5	5	--------
Public Utilities	3	3	--------
Hospitals, Sanitariums, and Dispensaries	1	1	--------
Railroads	3	3	--------
Insurance	94	86	4
All Others	1	1	--------
Total Number Reporting	161		

* A number of physicians are serving on more than one panel. (See Schedule B) Only the principal panel of each physician is used in this analysis.

As a number of physicians reporting that they were on panels stated that they were on "insurance panels" the distribution, according to the type of institution or organization they serve, is not as complete as it should be. Further effort to obtain this information, however, did not seem warranted because, as before stated, their compensation comes for the most part from the same source.

There can be no doubt that most physicians on panels feel that they are adequately compensated. Of the 161 reporting only six stated that the fees were inadequate. As there is no fee schedule in effect under the Wisconsin Workmen's Compensation Law most physicians exacted and received their regular fee. Some reported that insurance companies had endeavored to reduce fees below those ordinarily charged private patients of moderate means.

As in contract practice so in panel practice there were a number of physicians who served on more than one panel. (Schedule B) The panel in which it was apparent that the physician rendered the most service was selected for the purpose of this analysis of panel medicine.

Operation of Organizations Sponsoring Medical Service

It was evident to the Committee that no study of the subject of contract and panel practice would be complete without including pertinent facts about the operation of medical services sponsored by various organizations and institutions, and the approximate number of persons receiving medical care through them. No small amount of effort was necessary to obtain this information. Without the aid of a number of lay officials of corporations and lodges this effort would have been without result. Fortunately these officials were usually cooperative and willing to lend a hand, and the Committee feels that the facts determined are exceedingly valuable.

No effort will be made to present a complete analysis of all organizations and institutions sponsoring medical departments or services in Milwaukee County, as it is questionable if the value of this information would be commensurate with the cost of securing it. What the Committee wishes to present is an example of each type of contract and panel practice in Milwaukee County, after which the majority are patterned, and to present the pertinent figures concerning them.

Industrial Plants, Utilities and Business Establishments

Of the 42 industrial plants, utilities, and business establishments providing information for this study, 9 sponsored sick benefit associations. As sick benefit associations will be considered separately, no detailed account will be given of their operations here.

All establishments in Wisconsin employing three or more persons must, in accordance with the provisions of the Workmen's Compensation Act, insure their employees and provide medical service for them in event of injury, or for certain types of employment-connected illnesses. In consequence all of the industrial plants, utilities, and business establishments must have a panel of at least five physicians posted as required by law. Some in addition employ full-time physicians to render this service who, together with part-time physicians, serve on the panel.

In several instances physicians on the panel are also employed by the mutual aid or sick benefit association which the concern may sponsor jointly with employees.

There are auxiliary medical services (in addition to those provided by benefit associations) sponsored by a number of establishments. A few examples will suffice:

W Company—Has a first-aid hospital with a nurse in attendance. One of six physicians on panel is called "unless the employee has a physician of his own whom he prefers to handle the case." Two physicians on panel given preference by company over others. Medical service rendered to employees in addition to that provided for under the Compensation Act.

X Company—Sponsors group life and disability insurance; part of the premium paid by company and part by employees. Employee selects his own physician and pays own bills.

Y Company—Part-time physician employed to care for compensation cases. He gives "profes-

sional advice to some employees at times in cases that are in no way compensation cases. In addition (this Company) supplies employees with a considerable amount of medicine for minor ailments. This is usually dispensed by the nurse."

Z Company—"Have a registered nurse . . . in attendance on all working days. This nurse gives minor treatments as are required from time to time by people employed in the plant. Such medical treatments . . . are limited to headaches, small cuts, bruises, sprains, etc."

Medical services provided by industries, utilities, and business establishments may be classified as follows:

1. Medical and surgical care of employees as required by the Wisconsin Workmen's Compensation Act.
2. Medical and surgical care provided by sick benefit associations, sponsored by employers and employees.
3. Auxiliary medical and nursing service, viz: first-aid hospital, full-time nurse, full-time physician.

It was impossible to determine the number of persons who received treatment in industrial plants or through medical departments sponsored by them during 1931. Some figures, however, were made available by the Wisconsin Industrial Commission, which reveal the extent of medical service rendered in Milwaukee County under the Workmen's Compensation Act, and which approximately represent the work done in most industrial plants, utilities, and business establishments, aside from that supplied by affiliated sick benefit associations.

According to 1930 census figures, there were 311,364 persons gainfully employed in Milwaukee County. Due to the falling off of the labor market it is estimated that this number decreased 17% (52,931), and that in 1931 there were approximately 258,433 employed. Of this number approximately 66.6% or 172,116 came under the Workmen's Compensation Act. Based on its experience in the past, the Commission estimates that 9,811, or 5.7% of the total employed, received medical aid benefits during that year. It should be kept in mind that those listed as gainfully employed include not only those employed in private enterprises, but also by local governmental agencies, who are included in these figures.

Under the head of sick benefit associations will be found estimates of the number cared for by the 9 organizations providing the Committee with information.

Governmental Agencies

Federal—Physicians reporting contracts with the Federal Government are employed at the Veterans' Hospital. These men are on a salary which, as indicated in Schedule C, three physicians (of the five reporting) feel is inadequate. Part-time physicians are paid a maximum of $150.00 per month. Several, however, are paid less than this figure.

Some interesting figures as to the amount of work done have been made available for this study.

7,726 veterans received medical services in domiciliary barracks and hospitals during 1931.

5,593 of this number were hospitalized.

Major operations	1,821
Minor operations	393
Medical treatment	3,379
	5,593

1,372 (approximate) ambulant patients received medical treatment.

Under the present law all veterans, regardless of whether their disability is "service-connected," are entitled to medical and surgical treatment, which accounts for a great number of those being cared for at the Veterans' Hospital here as elsewhere.

In addition to local part-time and full-time members of the Veterans' Hospital Medical Staff there are, of course, other full-time physicians employed.

County—Physicians employed by Milwaukee County are civil service employees. Compensation of part-time physicians employed by Milwaukee County in 1931 was as follows:

District Physicians in the City of Milwaukee $120.00 to $150.00 per month.

District Physicians outside the City $55.00 to $75.00 per month.

Milwaukee County General Hospital and Dispensary Physicians*

6 physicians	at	$ 25.00	per month
16 physicians	at	50.00	per month
2 physicians	at	75.00	per month
1 physician	at	125.00	per month
1 physician	at	150.00	per month
1 physician	at	$250.00 to $333.00	per month

There were, on the average, 8 district physicians employed in 1931. Full-time physicians are employed as executives and in several medical departments at all county medical institutions.

The following figures indicate the amount of service rendered by these physicians and the unpaid and full-time medical staff of the County Hospital and the County Emergency Hospital and Dispensary:

25,475 patients received medical treatment at the County Dispensary in 1931.

14,188 patients were hospitalized in the Milwaukee County General Hospital during the same year. (Estimate: two-thirds received for major and minor operations, one-third, medical)

14,045 persons were treated by district physicians, of which number 2,344 were hospitalized.

15,171 persons received treatment at the Milwaukee County Emergency Hospital.

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* Paid according to time put in and type of service rendered.

For the first eight months of 1931, one district physician reported a monthly average of 193 home visits; another reported 104. No record was obtained of the number of persons receiving treatment in the Dispensary under each physician employed.

There were approximately 2,400 permanent employees of the County who came under the provisions of the Workmen's Compensation Act in 1931. These were included in the figures previously given in this report and which were supplied by the Wisconsin Industrial Commission.

State—Only two physicians reported that they were employed by the State. One was in service at the Wisconsin Industrial School for Girls and the other at the Wisconsin State Fair. Both held part-time positions.

City—More physicians were employed by the City than by any other governmental agency. They are also civil service employees. Aside from the full-time physicians a large number of part-time physicians were employed in child welfare stations, schools, and clinics. In addition there was a large unpaid medical staff at the Johnston Emergency Hospital.

The part-time physicians were compensated as follows:

29 School physicians, $81.00 to $96.00 per month (part time)
5 Child Welfare physicians, $125.00 to $150.00 per month (half time); $80.00 to $95.00 per month (part time)
4 Tuberculosis Clinic physicians, $60.00 to $200.00 per month (part time)

During 1931, 50,371 visits to Child Welfare stations in Milwaukee are recorded; 8,159 visits to tuberculosis clinics and 64,000 school children were examined by school physicians.

In addition to the above physicians there are those employed part time by the Fire and Police Departments. There are five police surgeons employed at a salary of $1060.00 a year. The Fire Department employs 3 physicians,—2 receiving $1060.00, and one, $1680.00. These physicians examine members of their departments to determine their physical condition. In addition they examined persons injured or killed in accidents, persons who commit suicide, and murder victims.

There were approximately 1,100 employees who came under the provisions of the Workmen's Compensation Act. This number fluctuated because of the number of temporary employees at certain times of the year. This group are also included in the figures provided by the Wisconsin Industrial Commission.

Lodges and Fraternal Organizations

So many protests have been made by physicians in Milwaukee County against practices of lodges and fraternal organizations sponsoring medical services that an energetic effort was made to ascertain the facts. The amount of information obtained was secured only after many calls on and interviews with representatives of these organizations most of whom were cooperative.

Sixteen lodges and fraternal organizations provided the following information contained in Schedule E:

SCHEDULE E

Report of 16 Lodges and Fraternal Organizations Sponsoring Medical Services in Milwaukee County

Number of Members	Type of Medical Service	To whom Service is Rendered	Cash Benefits	Compensation of Physician	Average Income of Member	Established Number Years
700	Medical	Members and family	Yes	$3 per member a year	$25 a week	15 years
68	Medical	Members and family	Yes	(38c single man) (75c married man) Quarterly	$20 a week	22 years
80	Medical	Members and family	Yes	(38c single man) (75c married man) Quarterly	$20 a week	20 years
80	Medical and Obstetrical	Members and family	Yes	$250 per year	$30-$40 a wk.	
2100	Medical	Members	Yes	$1 per member a year	$25 a week	17 years
600	Medical	Members	Yes	Paid by patient	$25 a week	
165	Medical	Members	Yes	$1 per member a year	$25 a week	1 year
800	Medical	Members	Yes	$700 per year	$25 a week	20 years
355	Medical	Members	Yes	$1 per member a year	$25 a week	30 years
450	Medical	Members	Yes	$1 per member a year	$25 a week	49 years
250	Medical	Members	No	$1 per member a year	$25 a week	44 years
385	Medical	Members	Yes	$400 per year	$25 a week	40 years
190	Diagnosis	Members	Yes	$2 per examination	$25 a week	24 years
60	Medical	Members	Yes	$100 per year	$25 a week	40 years
300	Medical and minor operations	Members	Yes	$400 per year	$25 a week	75 years
158	Medical	Members	Yes	$2 per member a year	$20-$25 a wk.	10 years

Included in the above schedule are so-called "sick benefit societies." The Committee has differentiated between what is termed a sick benefit association affiliated with a business enterprise and sick benefit society which in reality is a lodge or a fraternal organization with no such connections. Sick benefit associations will be discussed under another heading.

The above analysis reveals the type and kind of medical service provided. The majority of these organizations provide only medical service. In other words, surgery and obstetrics and other special services must be paid for in addition to lodge dues. In view of the small compensation paid physicians doing this type of work, the contracts offered can be made attractive only by the additional work which it is possible for the physician to obtain and which is not included in the lodge service.

While there is some variation in the compensation of the physician, an analysis of the above figures shows that the lodge physician is paid from $1.00 to $3.00 per year per member for the service rendered. Most lodge physicians are, however, entitled to extra fees for surgical, obstetrical, and fracture cases. These fees are usually the same as they charge their own patients.

As most lodges and fraternal organizations do not keep records of the amount of medical work done and as physicians' records are incomplete, it is impossible to show the exact amount of medical service provided by these organizations. This information would demonstrate the adequacy or inadequacy of compensation, although the number of members entitled to medical service in itself is indicative of the amount of service rendered. The reports of two physicians who were able to provide information as to the amount of work they did undoubtedly reflects the situation in other organizations.

Dr. A. reports that he made 1,126 home visits and 1,408 office calls during 1930–1931 for the lodge employing him. His compensation for this service was $1,295.00. Dr. A. was paid extra by members for surgical and obstetrical service, and for services rendered in fracture cases. Treatment for venereal diseases was also extra.

Dr. B. estimates that on the average he made 170 home visits and that there were 180 office calls monthly during 1931. He was paid $150.00 a month by the lodge employing him. Dr. B. was paid extra by members for surgical and obstetrical service and care of fractures and venereal cases.

The income of members or lodges and fraternal organizations, according to the estimates of their officers, was approximately $25.00 per week, or $1200.00 per year, on the average. If this estimate is accurate these persons may be termed "borderline" cases, insofar as their ability to pay for medical treatment in private practice is concerned. They are often, on the basis of the budget requirement of the Social Welfare Exchange, entitled to free medical care. Whether or not this is true depends on whether the member is head of a family, and the number of his children.

Most of these organizations have been in existence for many years. Five out of the 16 reporting state that they have been established more than forty years.

Sick Benefit Associations

We present here data gathered in regard to sick benefit associations affiliated with business, industrial plants, and public utilities. The operation of these associations is similar to that of lodges and fraternal organizations, except that they are not supported alone by contributions from employees. The employers usually contribute 50% and the employees the other 50%.

The following are representative types of sick benefit associations:

"A" Employees Club—This Club does not sponsor a medical service but pays cash benefits "to provide its members with a certain income in event of disability caused by sickness, or accident." During the continuance of the member's employment, his employers "deduct as a voluntary payment from any wages earned * * * the sum of twenty-five cents each semi-monthly wage check due * * * from said Company," which is paid into the treasury of the Club to the member's credit. In event of illness the member receives $7.00 per week, not to exceed three weeks, in a six-month period. There are some qualifications which alter these provisions to a limited degreee. The Club employs medical examiners to examine applicants for membership, and to report the condition of the sick and injured members. The member's own physician gives the necessary medical care, and his report as to the patient's condition may be accepted by the medical examiner.

This Club is affiliated with an industrial plant. The Company participates by taking out Company Memberships equal to the number of employee memberships, and paying like dues. The Club had 2,000 members in 1931.

"B" Mutual Aid Association—With 1,000 members this may be classed as one of the larger associations. In 1931, 7,000 office calls and house calls (calls in compensation cases included) were made to members and their families who, also, are entitled to medical care. Only medical care is given, surgical and obstetrical service being paid for by members individually. Members pay 12 and 15 cents a week into the fund of the association (deducted by Company from wages due), depending upon the type of sick benefit desired. No hospitalization provided for. Industrial plant.

"C" Employees' Mutual Benefit Association—The average membership of this Association in 1931 was 300. Medical service only is provided. In 1931 physicians employed by this Association made 222 home calls, 1419 office calls, and performed 100 minor operations. The average in-

come of employees was $20.00 per week. Employees paid $1.00 a month to the Association, and the Company contributed a like amount.

"D" Mutual Aid Society—A much more extensive service is provided for by this Society. Not only are members entitled to medical and surgical care, but also to the services of an eye, ear, nose and throat specialist. Hospital benefits, x-ray examinations, and special-nurse service are also included. The physician in charge is employed full time on a salary basis. He hires an assistant and pays him for his services. There is also an associate physician who is selected by the Society. Both the physician and the associate physician must be available for twenty-four hour service. In the event a specialist is needed the Society pays for the first examination and treatment but for no operation.

The Society pays eight consecutive weeks' hospitalization at ward rates except upon physician's statement that a private room is necessary. X-ray examinations made at Company's plant are also paid for by the Society as are prescriptions for drugs authorized by physician. Special-nurse service is provided for a period of four weeks.

The two physicians employed made 4,621 visits to homes of members in 1931. There were 6,229 office examinations, consultations or treatments, and 2,865 at the Plant Hospital. 109 major operations were performed and 610 minor operations. The average number of members of the Society during 1931 was 5003.

In addition to the above medical treatment, the eye, ear, nose, and throat specialist reported 467 hospital and residence treatments, 2,461 office consultations and treatments, 85 refraction cases, and 4,160 treatments at Plant Hospital.

Membership dues are 50 cents per month. The Company contributes a like amount. Physicians employed by the Society, excluding the specialist, received salaries which compensated them at the rate of $2.45 per member per year. Industrial plant.

An analysis of the remaining sick benefit associations providing medical service reveals that they belong to one of the above types. Some render more extensive service than even the "D" Mutual Aid Society. One sponsors not only medical and surgical services, hospital benefits, nursing service, x-ray examinations, but also the facilities of a pathological laboratory and dental service. This association had an average membership of 6,563 in 1931. Members paid dues of 75 cents per month; the Company contributed a like amount and, in addition, $113,000.00 for expenses. Only a part of these funds were disbursed for medical services. Association physicians' fees amounted to $5.74 per member per year, excluding the compensation received by the medical director and physicians other than association physicians.

As elaborate medical departments have been set up by the larger sick benefit associations associated with industrial establishments, no comparison is possible between them and the lodge and fraternal type which conduct a limited medical service. Compensation of physicians is not comparable as the benefit association is usually well financed with the assistance of the Company.

The total number of persons receiving medical care in one way or another as members of the nine sick benefit associations reporting was 17,626. This number does not include the families of members who are usually entitled to medical benefits.

Miscellaneous Institutions and Organizations

Most hospitals, sanitariums, and dispensaries employ full-time men. Service is rendered in these institutions to the general public. Hospitals and sanitariums are pay institutions. The one dispensary reporting is a charitable institution. Medical services in Homes for Children and the Aged are rendered by part-time physicians on a salary basis. Life insurance companies employ only full-time men on a salary or contract basis. Non-official public health organizations reporting, with few exceptions, employ full-time physicians on a salary basis.

Comments Made by Physicians on Contract and Panel Practice

Perhaps of more interest than the facts and figures gathered in this study are the comments of physicians in regard to contract and panel practice. In the final analysis theirs has been the experience of providing medical services under these conditions. Of particular value are the opinions of men of long experience. Their observations should be a guide to the Society in any conclusions to which it may come.

The following comments were made in regard to contract and panel practice:

Lodge Physicians

"I agree that general contract practice is harmful to everyone."

"With the additional services for which one receives fees, such as surgery and obstetrics, fractures, etc., the fee (salary received from lodge) is adequate. In other words, under our present system of general medical practice in this city, it is practically impossible to contact and build a large clientele to insure an adequate income, without having a 'feeder.' The lodge physician receives a flat salary for medical work done, but in sacrificing a part of the fees he would receive if paid for this work on a fee basis he is able to secure enough other work which is fee work to offset the loss. I believe that contract practice is of value in many

ways to the beginning doctor and does not seriously interfere with men established in practice. Since practically three-fourths of the active men in practice have a 'job', how is a young man to establish a practice unless he too has a way of getting patients?"

"I am against all panel and contract practice and would be happy to see them eliminated."

"I am opposed to contract and panel practice in its present form and would favor its abolition or at least its restriction by placing it under the supervision of the Medical Society."

Physicians Employed by Sick Benefit Associations

"This is the first year and also the last in which I will engage in this type of practice. People expect too much for salary paid, which is inadequate for services rendered."

"Most of the members (Mutual Aid Society) are not able to pay regular fees for services; and those who are, employ private physicians; the others need us—thus the pay is adequate. For various reasons I believe that industrial plants and industrial insurance companies must have experienced men in this field, and therefore for the best interest of all concerned, which includes the injured, must have a panel."

Industrial Physicians

"My charges are just what I charge my private patients when doing insurance work; and when doing diagnostic work I charge by the hour in accordance with what my time is worth in private practice."

"There is a tendency to dictation of medical practice by lay people (in contract practice) which might, under certain circumstances, become a detriment to the proper care of the patient."

City Physicians

"Have turned down lodge work, fearing it would eventually harm me as it has harmed others in the profession, since services rendered are usually not of my caliber."

"Some years ago I was a lodge physician. I believe members of -- lodge receive the worst possible medical service, and that the effect on the physicians themselves is disastrous."

"In general, children apparently needing corrective work (treatment for simple goitre, care of bad tonsils, bad teeth, etc.,) referred to the family physician receive far too little attention thereby depriving both the physician and the patient."

Panel Physicians

"I believe that contract practice is responsible for inferior medical service. The panel system gives other physicians an opportunity to do some industrial work and can therefore be tolerated."

"For my work which is done through the insurance panel I am paid whatever I ask, which I consider to be the same as in private practice."

"Seems to me that panel practice is fair to the doctors."

"Some panels are under the control of insurance companies who attempt to dictate the size of fees without reference to the quality of service rendered, an attitude which the Medical Society should combat."

"In insurance practice I am able to treat patients without limitations which might arise because of personal finances; to make use of the x-ray, hospital laboratories and specialists, without any sacrifice in my own field. I also enjoy the assurance of prompt payments without having to charge off bad accounts and collection costs. It has not been my experience that insurance companies are inclined to dictate as to the length and extent of disability."

"I think an employer or employee has a right to choose any reputable and capable man he desires. Personally, I do not like contract practice."

"Our objection (to panel practice) is that many doctors charge only $1.00 for subsequent dressings as a sales point; and then make up the difference either by making the patient come oftener or by charging a larger first-aid fee."

"I believe contract practice has a tendency to lower standards of medical service, as compensation and practice do not depend on the quality of service rendered and the results. Panel practice, especially on a fee basis, is justified, as good service is rewarded, and a doctor is continually in danger of removal from the panel for inefficient type of work."

"Believe medical societies should apportion industrial work among physicians nearest various factories. Physicians and surgeons should not be able to 'corner' business as some are doing as present. In-

competent men should be judged by a Medical Society Committee."

"I have taken care of other doctors' contract practice and while these contracts were considered ethical, I know that the patients are not given the same treatment as private ones and the doctors receive from one-third to one-half the compensation they should."

"Panel insurance practice, if the panel provides a good selection for the patient, can hardly be avoided. The fees are reasonable."

Comments by Other Physicians in Contract and Panel Practice

"Panel practice without written contract is ideal. This encourages conscientious work, produces trained men, and guarantees the patient, as nearly as possible, the maximum of efficiency. I am not in favor of salaried physicians the causes being so numerous one hesitates to begin to name them."

"I am a believer in organized medicine. But if a man in contract or panel practice should be forced to discontinue this practice, what guarantee has he that no other doctor will take over his 'agreement'?"

Physicians Not In Contract or Panel Practice

"Contract practice is undoubtedly justified under certain conditions but for the most part is the legitimate child of greed and trade unionism."

"Panel practice I feel will continue because it is out of the hands of medical men and in the hands of politicians in medicine."

"I have no objection to panel or contract work if paid for on a fee basis providing the fee is the usual one for the community; but I object to a salary basis because it usually results in inadequate fees."

"Years ago I was a lodge doctor; when I saw that it was not just to patients and the doctor, I gave it up."

"I wish to state that I strongly endorse your work along these lines. All contract and panel work should cease. It is high time we awaken."

"I have had two years' experience with fraternal practice in which my services were satisfactory, but my experience convinces me that this practice is not in keeping with the best interests of the profession."

"The only condition under which contract practice should be sanctioned is where adequate service is rendered and a commensurate return made in keeping with the high standard, honor, and dignity of the profession."

"Your name may appear on a panel which helps the corporation to comply with the 'letter' of the law, but if the powers that rule don't want you to get any of their business you don't get any. The poor employee 'listens' to the boss to keep his job."

"Panel choice is, in my opinion, a more intelligent choice than individual choice."

"I believe that contract practice, particularly as exhibited by our large utility and some industrial concerns works a hardship on the medical profession. Further, and more important than any other consideration, the need for such practice has never been demonstrated in communities like Milwaukee where there is no scarcity of competent medical men. Nor are the employees and their families given any better care under contract than those who are not similarly attended.

"We are told that certain industrial plants do not do anything other than advise treatment where needed; none of the work is done by the so-called plant doctors. The fact remains, however, that a sort of dignified censorship is maintained in the selection of those to whom these patients are referred. So here again the patient is not permitted to exercise complete freedom of choice."

It is not possible to give here all of the statements made in the schedules, because 122, or approximately 22%, of the physicians reporting commented on some phase of contract and panel practice. Those presented above reflect quite accurately the character of all the comments. In a study of this kind it is perhaps the tendency to voice unfavorable rather than favorable opinions. A number of physicians now engaged in contract practice stated that they were not in favor of contract practice and would like to see it abandoned. Most physicians answering the schedule seemed to favor the panel system if the fees paid were fair in comparison to those charged in private practice.

Conclusions

1. It is important in considering the facts set forth in this study to keep in mind that contract and panel practice are quite different types of medical practice. In panel practice, for the most part, the physician

renders treatment as required under the Workmen's Compensation Act, and carries on this type of medical practice in his own office the same as he does his regular private practice. There are a few exceptions to this, notably those who specialize in industrial practice.

As there is no fee schedule established under the Compensation Act most physicians doing this work charge their regular fee to people in ordinary circumstances.

Panel practice differs in Wisconsin from private practice only in that it restricts the choice of physician by the patient. Some insurance company representatives insist, however, that the panel, even in large centers such as Milwaukee, is largely theoretical. That, where a patient chooses a physician who is not on a panel, insurance companies do not object if the patient receives adequate medical care, and the physician does not exceed the charge which he would make an ordinary patient for the same service. To emphasize this contention a committee of insurance company representatives, in a session with the Committee on Insurance of The Medical Society of Milwaukee County, authorized an effort to ascertain the number of physicians willing and capable of doing compensation insurance work, indicating that they wished to develop a plan which would allow for as free a choice of a physician by the patient as possible.

Contract practice, however, implies a contract, written or verbal, whereby the physician agrees to render a specified service for an agreed sum or fee. This embraces a large group of physicians in Milwaukee County employed by industrial plants; governmental agencies, i. e.,—federal, state, county, and city; lodges and fraternal organizations; sick benefit associations; hospitals, sanitariums, dispensaries; homes for children and the aged; insurance companies, and a miscellaneous group. The study indicates that a number of the physicians employed by sick benefit associations which are affiliated with industrial plants, utilities, and business establishments, also serve on the panels of these concerns.

2. Recognizing the importance of the problem under consideration physicians in Milwaukee County supported the study to an extent which most optimistic members had not dared to hope. All those having knowledge of the progress of the study agree that returns from 544 out of the 657 physicians to whom schedules were sent is quite remarkable, and is sufficient evidence that the membership of the Society wish the facts to be determined. What is of greatest importance, the majority of those reporting were frank in providing information and did not hesitate to give the information requested. The Committee concludes from this showing that the Society desires to definitely determine a course in the disposition of contract and panel practice.

3. That hasty or drastic action in regard to contract and panel practice might be disastrous must be evident to those studying this report. With more than 50% of the membership engaged in some form of contract and panel practice ill-advised action might seriously disturb the unity of the profession in Milwaukee County which is so essential to its welfare in critical times such as these.

4. An offhand observation of contract and panel practice in Milwaukee County might lead one to believe that this type of medical practice was perhaps concentrated in few hands. The study reveals that the opposite is true. In contract practice 150 of the 179 physicians reporting state that they hold only one contract. The others vary from one to four contracts, most of them being what may be called "small" contracts. In panel practice the picture is somewhat different although it does not definitely alter the situation. Sixty-four report that they are on one panel. Forty-two report that they are on two or three, and 45 are indefinite. Only 10 state definitely that they serve on more than 3 panels.

While there is apparently more concentration in panel practice it must be kept in mind that a number of physicians serve on more than one panel of insurance companies from whom they receive but a small amount of work. It is fair to assume, the Committee believes, that panel or contract practice is quite widely distributed among the physicians reporting their activity in this field.

5. The Committee feels that it is of especial significance that of the 179 physicians reporting contracts that 67 are employed by governmental agencies, and 62 are engaged by lodges, fraternal organizations and sick benefit associations. If the 14 employed by industrial plants are included, this number accounts for 143 physicians. The remaining 36 physicians are for the most part full-time men in the employ of sanitariums, hospitals, life insurance companies, etc.

It is important to observe in this connection that all physicians stating that they were inadequately compensated are engaged in lodge and sick benefit contract practice or employed by governmental agencies. Twenty-seven of these stated that they were inadequately paid, and 51 that their compensation was adequate.

6. An analysis of panel practice shows the affiliation of 161 physicians with a panel of some establishment or insurance company. All, with a very few exceptions, are rendering services under the provisions of the Workmen's Compensation Act. As has been stated before, the major complaint that physicians have against panel practice is that it does not entitle the patient to a reasonably free choice of physician. That this difficulty may soon be solved has been indicated.

That physicians serving on panels feel their compensation is adequate is clearly reflected by the schedules returned. Only 6 of the 161 reporting state that their compensation is inadequate.

It would seem that according to the facts obtained and the impression given by those physicians who appended their schedules with remarks, that the medical profession in Milwaukeee County does not seriously object to panel practice providing there is a reasonable and fair choice of physician by the pa-

tient. A few indicated unsatisfactory relationships with insurance companies and felt that there should be unrestricted free choice which would necessitate a change in the law.

7. The information furnished the Committee by the various industrial, utility, and business concerns, governmental agencies, lodges, fraternal organizations, and sick benefit associations was considered of equal importance to that obtained from physicians. No attempt has been made to present detailed information as to operation of medical departments and services. Facts essential to present an adequate picture of contract and panel practice from the sponsors' viewpoint was considered sufficient. As will be indicated later an effort was made to determine the number of persons who are beneficiaries of the medical services provided.

Industrial Plants, Utilities, and Business Establishments

The report of 42 industrial plants, utilities, and business establishments verified the facts determined from schedules that few industrial plants in Milwaukee employ full-time salaried physicians to care for their employees. Thirty of those providing information said that they did not employ full-time physicians or sponsor benefit associations. The majority depend on their insurance panels for necessary medical attention in accident and injury of their employees. Nine of the 42, however, report that they sponsor sick benefit associations. Nearly all of these employ full-time or more than half-time physicians. A number report that they sponsor first-aid hospitals and employ full-time nurses. Objection should be made to the service rendered by some nurses, according to reports of a few industrial companies. One company frankly informs the Committee that their "nurse gives minor treatments as are required from time to time by people employed in the plant. Such medical treatments . . . are limited to headaches, small cuts, bruises, sprains, etc."

The State Medical Society recently published Standing Orders for Registered Nurses Employed in Industrial Plants, which if followed would eliminate medical treatment by nurses. The Committee feels that added pressure should be put behind these rules. Continuance of medical treatment by nurses is dangerous to the patient because it is beyond their ability.

Governmental Agencies—An analysis of figures presented in connection with part-time contract physicians employed by all governmental agencies indicates that they are underpaid if compensation for the same type of service in private practice is used as a comparison. Many physicians doing this type of work, however, consider themselves well paid in other ways. Some mention "contacts" which prove valuable, others welcome the additional income.

As has been pointed out on a number of occasions there has been a gradual tendency toward expansion of medical services sponsored by governmental agencies, and the medical profession has not been a little alarmed. That to stay this expansion the medical profession must come forward with constructive measures is self-evident. The obvious conclusion is that organized medicine must develop a plan whereby this medical service would be provided to the satisfaction of the public and the physician. This is a large order and one which is concerning the medical profession everywhere. At this time The Medical Society of Milwaukee County is giving such a plan careful thought. Certainly no serious consideration by the public and the many physicians engaged in this type of practice would be given to any other course.

Lodges and Fraternal Organizations—So many protests have been made by the medical profession against the type of medical service sponsored by lodges and fraternal organizations that the Committee made a special effort to obtain information which would reflect the true situation in this field. Sick benefit associations of the type sponsored by various business enterprises were excluded from this phase of the study.

On the basis of information provided by officers of 16 lodges and fraternal organizations the Committee feels that it is conclusively shown that for the service rendered, either the physician employed is underpaid or the patient receives inadequate service. Despite the fact that few lodges and fraternal organizations keep records of medical services rendered, it was possible to obtain information from a few physicians indicating that many made house calls and rendered medical treatment to patients visiting their offices for less than fifty cents per call or visit. Information provided previous to this study by one lodge physician indicated that he was making calls for as small an amount as twenty cents.

Physicians employed in this type of work defend it on the basis that the extra surgery and other special work not paid for by the member in his lodge dues more than compensate him for the work he does below his regular fee. The argument is also advanced that the beneficiaries of these schemes would not obtain medical service otherwise, unless they became charity patients.

It is obvious to the committee that these arguments are not tenable. While it does not question the sincerity of some of these physicians and their endeavor to render adequate medical care, too often the schemes sponsored by these organizations are reduced to a "racket" with the result that the patient suffers. The best evidence of this are the reports of a number of physicians that patients coming under some lodge scheme of medical service do not call the lodge doctor because they wish good medical care.

Certainly the medical profession should take an emphatic stand against the "racket" practice and, without unfairness to individuals, stamp out all that is undesirable.

Sick Benefit Associations—Not all sick benefit associations sponsor a medical service. As indicated in the study some provide only cash benefits which make it possible for the patient to employ the physician of his choice. Several, however, sponsor large medical departments with special facilities equal to the best available in the community. The fact that medical and hospital benefits are provided to a substantial portion of the industrial population; that the type of service rendered is generally adequate; that the physicians employed are more liberally compensated than is possible by lodges and fraternal organizations makes this a distinctive problem. It is a fact that sick benefit associations in sponsoring medical services have brought about a situation which has resulted in a great deal of controversy among the medical profession.

While the suggestion is frequently advanced that an effort be made on the part of the medical profession to have the medical departments of these associations discontinued, such a course would be ill-advised without some constructive plan to replace the need which they seem to fill in the community. The situation suggests that the legality of the arrangement under which these corporations sponsor sick benefit associations be studied, and an opinion covering the ethical problems involved be secured from the American Medical Association.

8. Nothing will emphasize the extent of contract and panel medical practice more than a consideration of the number of persons receiving medical service from the organizations and institutions coming within the scope of this study. This alone must impress the medical profession that it is one which cannot be dealt with hastily without jeopardizing the welfare of the public and the medical profession.

Recommendations

On the basis of the facts ascertained the Committee begs to submit the following recommendations for the consideration of the Board of Directors of the Society:

1. It is recommended that this report be published in an early issue of The Milwaukee Medical Times.

2. It is the opinion of the Committee that the subject of contract and panel practice warrants further study by the Society, and the Committee recommends that the work be carried on under the direction of the Board of Directors.

3. The Committee believes that in the best interests of the public and the medical profession, the medical panels set up under the provisions of the Workmen's Compensation Act be enlarged to include all physicians willing and capable of doing compensation insurance work, and recommends that every effort be put forth by the Society to attain this objective.

4. The Committee recommends that serious consideration be given to the development of methods to be sponsored by The Medical Society of Milwaukee County providing better and more adequate medical service to individuals in the lower income groups.

5. In the interest of better medical service to the public the Committee recommends that serious consideration be given to the invasion of private medical practice by local, state, and federal governmental agencies.

6. Information at hand relative to sick benefit associations sponsored by industries is not sufficient to serve as a basis for any definite recommendations other than that a special sub-committee under the supervision of the Social Medicine and Medical Economics Committee of the Society, be appointed to give further study to the medical service provided by this particular group.

7. This Committee calls to the attention of the Board of Directors the fact that this study apparently discloses a type of medical service being rendered by some few of its members, that is below the standards of service to the public which organized medicine is attempting to maintain, and the Committee recommends that this matter be given immediate and serious consideration.

Respectfully submitted,

Social Medicine and Medical Economics Committee of The Medical Society of Milwaukee County

Dr. S. J. Seeger, *Chairman,*
Dr. W. M. Kearns,
Dr. J. C. Griffith,
Dr. Charles Fidler,
Dr. Edwin B. Gute,
Theodore Wiprud, *Secretary.*

ADDENDUM NO. I

THE MEDICAL SOCIETY OF MILWAUKEE COUNTY

SCHEDULE ON CONTRACT AND PANEL PRACTICE

Contract Practice

Definition of Contract Practice

The Judicial Council of the American Medical Association has defined "contract practice" as follows:

"By the term 'contract practice' as applied to medicine, is meant the carrying out of an agreement between a physician or group of physicians as principals or agents and a corporation, organization or individual, to furnish partial or full medical services to a group or class of individuals for a definite sum or for a fixed rate per capita."

To clarify this definition, it may be stated that any physician having a verbal, written, or implied agreement to render medical services to any group, institution, or organization, whether for a specified fee or sum, is engaged in contract practice.

(1) Do you care for any of your patients under provision of a contract agreement as defined above? (Yes or No) _____

(2) If you are doing contract practice, please answer the following questions:

(a) With what institutional concerns, business groups, or other groups have you a contract?

_____
_____
_____
_____

(b) Over what period of time does your contract hold?

_____

(c) If your contract is with an industrial or business establishment, or governmental department, is the medical service limited to employees? (Yes or No) _____
If not, what portion of the employee's family is included?

_____
_____

(d) If your contract is with a lodge, fraternal group, or benefit association, is the medical service limited to members? (Yes or No) _____
If not, what portion of the member's family is included? _____

_____
_____

(e) What types of medical care are guaranteed to patients under your contract?

(1) Employment connected injuries? _____

(2) Employment connected illness and injuries? _____

(3) Illness and injuries regardless of whether they are employment connected or not?

_____

(3) Who pays for your services under your contract?

(a) Patient? _____
(b) Employer? _____
(c) Employees? _____
(d) Benefit Association? _____
(e) Insurance Company? _____

(4) Is the compensation derived from your contract practice adequate for the rendering of good medical service based on the usual medical fees paid for the same kind of service and class of people in your community? (Yes or No) _____

Panel Practice

(1) If you are not engaged in contract practice, are you serving on a panel sponsored by a governmental department, (state, city, or county), business establishment, industrial plant, mutual benefit association, fraternal organization, insurance company, or any other institution or group? (Yes or No) _____

(2) If so, will you state below the panels on which you are serving?

_____
_____
_____

(3) Are you paid on a fee or salary basis?_____
If on a fee basis, do you charge the usual medical fees paid for the same kind of service and class of people in your community? (Yes or No)_____

REMARKS: (Any comments which you have to make on the subject of contract and panel practice, or your relation to it, will be appreciated.)

_____
_____
_____
_____
_____

_____M. D.

Date_____

(Please return this form when completed to The Medical Society of Milwaukee County, 606 W. Wisconsin Avenue.)

ADDENDUM NO. II

THE MEDICAL SOCIETY OF MILWAUKEE COUNTY

SCHEDULE ON MEDICAL SERVICE SPONSORED BY BUSINESS ESTABLISHMENTS, INDUSTRIAL PLANTS, MUTUAL BENEFIT ASSOCIATIONS, LODGES AND OTHER ORGANIZATIONS

(1) Name of organization? _____

(2) Address? _____

(3) Type of Medical Service sponsored? (Diagnosis only, or both diagnosis and treatment) _____
_____

(4) Is the medical service limited to employees only? (Yes or No) _____
If not, what members of employee's family are included? _____
_____

(5) If mutual benefit association or lodge, is medical service offered limited to members? (Yes or No) _____
If not, what members of the family are included? _____
_____

(6) How many employees were entitled to medical service in 1931? (Average) ----------

(7) If families receive medical service, how many members were entitled to such service? (Average) ----------

(8) If mutual benefit association or lodge, what was the average number of your members in 1931? ----------

(9) How many employees or members (including members of families if entitled to such services) received medical attention in 1931? ----------

(10) To what kind of medical treatment were your employees or members entitled? (Surgical, medical, obstetrical or hospital) ----------
---

(11) Medical service rendered during 1931?
- (a) Home calls
- (b) Hospital calls
- (c) Office calls
- (d) Major operations
- (e) Minor operations and obstetrical

(12) What was the average income of those receiving medical care? ----------
---

(13) What did they pay for medical services received?
- (a) Monthly payments $-------- and part of medical fee (detail)------
  ---
- (b) Paid by employer $--------?
- (c) Retained from salary or wages $--------?

(14) When did your organization establish a medical service? ----------
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REMARKS ----------

REPORT

of

THE SPECIAL COMMITTEE

Appointed by the Council of the Wisconsin State Medical Society April, 1932, to Investigate Any and All Procedures of Admittance of Patients to the State of Wisconsin General Hospital and Report its Findings and Recommendations to the House of Delegates

The Committee

REGINALD H. JACKSON, M. D., *Chairman*, Madison
(Incoming President, Wisconsin State Medical Society, Madison)

*GUNNAR GUNDERSEN, M. D., Ex officio, La Crosse
(Regent, University of Wisconsin)

STEPHEN E. GAVIN, M. D., Fond du Lac
(Councilor of the 6th District)

FRANK W. POPE, M. D., Racine
(Councilor of the 2nd District)

ROCK SLEYSTER, M. D., Wauwatosa
(Trustee American Medical Association; Past President Wisconsin State Medical Society)

GREGORY CONNELL, M. D., Oshkosh
(Past President, Wisconsin State Medical Society)

JOHN L. YATES, M. D., Milwaukee

THOMAS J. O'LEARY, M. D., Superior

DREXEL DAWSON, M. D., Rice Lake

JOSEPH DEAN, M. D., Madison

GEORGE CROWNHART, Ex Officio, Madison
(Secretary of the Wisconsin State Medical Society)

* Resigned, Sept. 15, 1932. See Proceedings, House of Delegates.

Introduction

The State of Wisconsin General Hospital was authorized in the special legislative session of 1920 and opened in October, 1924 under Chapter 142 of the Wisconsin Statutes. While the statutes specifically provided for the care of the "public patient" at joint state and county expenses, the initial regulations of the hospital provided for two additional classes of patients, viz., the private pay patient from whom the hospital and attending physician collected full fees, and the so-called "clinic case" defined in the regulations.[1]

Financed from a surplus in the soldier bonus fund, the Hospital was erected as a soldier memorial with a joint function of care of the public patient and of serving as a teaching center for the University of Wisconsin Medical School.

The medical profession of Wisconsin, as represented by the State Medical Society, has on more than one occasion adopted resolutions and memorials looking towards the perfection of the Medical School at the State University. Long before a medical school existed the Society had interested itself to the end that proper medical services might be available for the poor and indigent. The extent and public nature of this effort is well known to every interested person, and the great contribution of the profession in Wisconsin estimated this year by your Special Committee on the Distribution of Medical Services as representing a sum in excess of six million dollars annually is approached by no other group or class of individuals and indeed is far greater than the total of all community chest funds ever raised within the boundaries of the state.

As was stated by Mr. George Crownhart, Secretary of the State Medical Society,[2] "Almost since the opening of the Wisconsin General Hospital, objections have been received from physicians to either the methods or actual commitment of patients in all three classifications."

On at least two occasions officers of the Society have made partial investigations covering the so-called clinic case, and reported instances of abuses of other classifications have been investigated as individual cases. Because no complete report had ever been issued viewing the institution as a whole, and because criticisms continued to be received in mounting numbers, the Council at its meeting in April last authorized your present special committee to study the entire subject matter. In order to preclude the possibility of influence or personalities entering into this study, your Committee determined to have its factual studies made by a firm of certified public accountants. This procedure was approved by the Council with an appropriation to defray the expenses, assuming that the suggested arrangement would be acceptable to the governing authorities at the Hospital. The Chairman of the Committee was directed to endeavor to perfect this arrangement and to present requests for the data desired as might be agreed upon from time to time by unanimous vote of the Committee.

The findings of the accountants, together with certain correspondence between your Chairman and Dr. Buerki, Superintendent of the Hospital, and Dr. Bardeen, Dean of the Medical School and Chairman of the executive committee of the Hospital, will be found as an addenda to this report.

At the first meeting of your Committee all were in accord with the thought that if the investigation disclosed procedures that did not operate in the broad public interest, every effort should be made to secure change by conference with those directly charged with the management of the institution rather than through resorting impetuously to any request for legislative action.

Your Committee was in complete agreement that its every effort would be employed to prevent a situation that has grown in other states leading to an embittered division between the general practitioners of the state and those physicians employed at the medical school and hospital. We desire to be the first to suggest that the problems herein presented are, in their final analysis, a single one of how the public interest shall be served. We have studiously avoided any method of approach that would becloud this clear end for we are not aware of any measure that ever conferred any lasting benefits upon the public health that did not at once advance the interests of every physician, nor do we know of any measure that has advanced the profession of medicine that has not given even more generously of public benefit.

It has been the misfortune of the public in some other states to have witnessed a continuous warfare between the private practitioners and those in the state employ over questions of public policy. In such states the physicians at large have been charged with an effort to advance pecuniary and essentially selfish interests. And likewise in these states the school of medicine has been under continual fire as an institution more interested in promoting the size of the pocketbooks of its staff than in the care of the poor. The public has not had the advantages which a close cooperation could have brought and all too frequently has been drawn into a conflict by appeal of the demagogic type.

The profession of medicine "has always been assailed from without by those unaware of the in-

[1] "Clinic patients are patients admitted upon the recommendation of a physician or of a responsible official with a statement that they can pay the cost of hospitalization but that a professional fee in addition would be a severe handicap."

[2] Special report to the Council, April 8, 1932.

finite perplexities of its labors" but inasmuch as our present effort is in the joint interests of the school of medicine, the private practitioners, hospitals of the state and the general public whose aim should be a common one, we conclude this introduction by expressing the hope that all concerned with the report will give to it their considered thought that resultant action may not be that type of strife so easy to fan and whose flames are so destructive of all growth.

Findings—County Cases

Your Committee is greatly impressed by the wonderful service for the indigent sick which the Institution provides but it is only too obvious that unless the State continues to add many hundreds of additional beds to the present institution that only a selective list of these patients can receive this care. Inasmuch as the primary object is to provide as good professional and hospital care as possible for this type of patient, comparable in fact to that which the rest of society deems necessary for itself, the question arises, whether the State of Wisconsin General Hospital is the only institution in the State where such care and professional attention is to be available?

It is the opinion of your Committee that during the past 25 years there has been developed in the various sections of the State of Wisconsin medical centers equalling in construction and equipment of buildings, professional and nursing personnel, any development in any state in the Union comparable in size and population to Wisconsin. Possibly there has been an unwise overdevelopment but the fact remains that these institutions in the aggregate provide many hundreds of hospital beds,—nearly 50 per cent of which during the current depression are empty. It is purile to advance the argument that because these institutions are not state owned or controlled they cannot be used for the care of the indigent sick. These modern institutions have been erected by the generous response of many thousands of Wisconsin citizens who realized their local hospital needs.

To view a situation which has obtained for sometime in which the State of Wisconsin General Hospital is so over-crowded and besieged by applicants that it has been necessary to place patients in already crowded wards, while the districts from which they come contain 50 per cent of empty beds in first class hospitals, give us concern lest its continuance and development lead to an unnatural segregation adding unnecessary burdens to the costs of illness for the pay patient.

The funds necessary to care for the indigent or part-pay patient can come only from taxation, charity or adding to the overhead of the pay patient. The subsidy proffered to counties in the form of state aid to the extent of $2.38 per patient day has served the purpose of filling to capacity the State of Wisconsin General Hospital and providing the teaching material so essential to the College of Medicine. But with the number of clinical students limited in the Junior and Senior years to approximately 100 (including both classes)[3] there can be no good reason for any enlargement of the Wisconsin General Hospital for the purpose of taking care of more indigent sick patients for teaching purposes, nor is there now nor should there be in the future, any need for similar institutions in other parts of the State. This state subsidy is after all paid by the state's residents. The whole problem of the care of the indigent sick is so complicated and, from its present administration, so unsatisfactory in many ways, that your Committee makes the following recommendations:

1. That the President of the Society be empowered to appoint a special committee consisting of 12 members of the society to investigate the entire subject and prepare and have presented to the Legislature at its coming session bills to improve this type of service primarily from the standpoint of insuring better service for the indigent sick and secondarily from the point of utilizing facilities of the proper type already available but which are largely unused at present because the only remuneration which said hospitals can receive for such service per patient through the office of the County Judge, is about $2.50 per day, a sum which is inadequate to pay for the proper care including special diagnostic features which are just as necessary in the proper diagnosis of an indigent sick person as a well-to-do one. The mere fact that some of these institutions are, and more of them could be, used as teaching hospitals for fourth year medical students, at present stamps them as being worthy adjuncts to the College of Medicine and fully entitled to proper recommendation for caring for such of the indigent sick as could with propriety be placed in their care.
2. That an invitation be extended by the Society to the Wisconsin Hospital Association to join in this investigation with a request that 12 representatives of the Hospital Association be appointed to work in collaboration as members of a joint committee.
3. That the Committee be instructed to endeavor to secure changes in the present laws of state or counties to provide that the medical attendants on the indigent sick whether in homes or institutions will receive some, however small, just remuneration for these services.

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[3] See Bulletin of The Medical School, University of Wisconsin, page 54, 1932–33.

4. That the Wisconsin General Hospital authorities continue and enlarge upon their efforts initiated this spring to educate referring officers as to the exact types of cases needed at the state hospital to serve its educational purposes that the beds may not be unnecessarily used to serve that class of indigents who serve no teaching purposes and for whose care adequate facilities exist at home.

Findings—Clinic Cases

Inasmuch as this particular class of admission case has been a source of continued and increasing irritation and criticism on the part of active practitioners of medicine, your Committee feels that a very frank and open expression of opinion should be made based on its studies.[4]

1. It has undoubtedly been the opinion of many members of the Society (as it has been of the members of your Committee) that patients could only be admitted under this classification when presenting a letter from a physician stating that in the knowledge of the physician this patient was entitled to and could pay $5 a day for this largely specialized service, the letter stating also that it would be a "financial hardship" to pay a professional fee in addition.

On several occasions when the subject has been up for discussion before component bodies of our Society, the impression has been left indelibly by those speaking on behalf of the State of Wisconsin General Hospital that any errors in the admission of this class was the fault of the referring physician, that this particular type of case admittance was devised for and its control rested solely with the referring practitioner.

Thus, Dr. Buerki, superintendent of the hospital, in speaking before the meeting of the County Society secretaries, 1931 (Address before County Secretaries meeting, Wisc. State Med. Journal, page 414, paragraph 5, selection of patients) stated "Physicians in private practice send in the Clinic patients."

Dean Bardeen in a communication to the Special Committee of Dane County Medical Society in April, 1932[5] said in part, "At present, the use of the service (Clinic cases) rests in the hands of the profession."

Dean Bardeen also said in his communication, "The relative *number* of clinic patients at the hospital has been steadily decreasing. In the early years of the hospital, it ran as high as twenty per cent; in 1930–31 it was 14.3 per cent; in 1931–32 it was 9.5 per cent; at present it runs about 8 per cent." Furthermore

A statement was made before the meeting of county secretaries as follows: "It may be of interest to know that shortly after the hospital was established the percentage of admissions per hundred cases were:

State	75%
Clinic	15%
Private	10%

For the first six months of this calendar year (1931) the percentage table is now changed to read:

State	79%
Clinic	12%
Private	8%

The decline in *numbers* of clinic and private cases and turning upward of the numbers of state cases is obvious."

The tabulation chart shows that the actual number of private and clinic cases in 1930 (full year) was 3,118, whereas the figure for 1927 was 2,960, an actual increase in *number* of cases of 158.[6]

Secretary Crownhart, in his special report to the Council April 8, 1932, in re the matter of the clinic case at the State Hospital stated, "In 1930 I investigated a case from Stevens Point which was admitted on the basis of a telephone communication by a physician from Milwaukee. It was discovered that this case should not have been admitted on a clinic basis and as a result it was suggested to the hospital authorities that no clinic case should be admitted without a letter or full memorandum in the files. This suggestion was adopted and it is understood that every clinic case at the State Hospital for the last two years has a file, one portion of which is the letter from the physician asking the hospital to accept the case on a $5 a day basis."[7]

2. It has also been the impression among private practitioners that the figures announced from time to time by the management of the institution in regard to the decreasing percentages of this type of admittance were based on actual individual patients whereas it is brought out clearly by the report of Elwell & Kiekhofer that the figures given out were based on patient days in hospital, a method whereby, for instance, a county case hospitalized for two months would balance four clinic cases staying 2 weeks each. Thus, out of the 2,158 consecutive admittances (all classes) examined by the auditors the per cent of clinic cases as separate admissions was 21.73%. This is also brought

[4] See Addendum No. V, page 1, for assumed advantages and objections to clinic cases.

[5] See Addendum No. I.

[6] See Addendum No. II.

[7] See report of auditors on telephone admissions, etc., of clinic cases. Addendum No. II, page 6.

out strikingly in the tables prepared by the hospital authorities and included as exhibits 1 and 2 in the auditors' report, Addendum No. II.

	1927	1928	1929	1930	1931	1932—5 mo.
Per cent figured on patient days	16%	16%	16%	15%	10%	8%
Per cent of actual individual admissions	32%	31%	30%	27%	21%	14%

The fact that it was also the policy of the Institution to admit patients to this classification on the statement of a "responsible official" presumably without the required letter from a physician is brought out clearly in the report of Elwell and Kiekhofer.

We recommend that if the clinic case be continued the regulations be amended to eliminate this type of reference for its continuance is to suggest that the layman referring the case has that medical education which permits him to know when specialized care is required.

A reading of the auditors report (Add. No. II) discloses the fact that the hospital authorities refused information to check up on the economic status of "clinic patients." Your committee feels that this was most unfortunate.

The Council had appropriated funds for an independent credit report on any clinic patient whose hospital file, in the opinion of the auditors, did not give satisfactory evidence of proper admittance according to economic status. In our opinion, no violation of professional confidence would be involved in ascertaining the economic status of a given citizen who had obtained service in a public institution or the representation that he or she was semi-indigent. The question of diagnosis was not raised.

At the meeting of your committee June 17, 1932, it was unanimously agreed that inasmuch as the hospital authorities had refused to permit the committee to take ANY names of clinic patients from the records, the suggestion offered of permitting the auditors to investigate the economic status of every tenth "clinic case" in the files be not accepted. It would, in the opinion of your committee also be a violation of the position taken by the hospital authorities if we should present for investigation the names of the specific complaint cases filed with it.

The membership of the society has had experience with the "clinic case" since the opening of the State of Wisconsin General Hospital in 1924, and should by this time, have been thoroughly satisfied with it if it offers the advantages held forth by its advocates for the public and the profession.

Question No. 1, in the questionnaire[8] sent in June to members of the Society was as follows:

"Would it, in your opinion, be to the best interest and continuing welfare of the profession as a whole and the public to recommend the continuance of this class of admission to the State of Wisconsin General Hospital?"

The replies were as follows:

Yes _____%. No _____%.
Numbers _____. Numbers _____.

Your committee is of the firm belief that not only in Wisconsin but that throughout America in general wherever the opportunity is provided to receive surgical and medical services in municipal, county, or state hospitals which, of themselves, are of modern construction and equipment and yet do not in their name carry any implication of charity, an ever increasing percentage of patients who are able to pay private practitioners and private hospitals for the necessary service, are willing recipients of the public charity thus extended to them and will resort to evasion, subterfuge, and political influence to obtain it.

Your committee is unanimous in its belief that it would be for the continuing best interests of the public welfare and the medical profession, including the College of Medicine of the University of Wisconsin, should this so-called $5 a day clinic case be abolished.

We believe that in order that no truly worthy semi-indigent patient in the state of Wisconsin shall be denied the possible benefit of new diagnostic or treatment measures, such as, for instance, the use of a radium emanation plant, or of a special apparatus such as an air chamber or other special diagnostic or remedial measure, there should be inaugurated a new type of admittance to the State of Wisconsin General Hospital to be officially designated as "The Special Clinic Service for Semi-Indigents" for the express benefit of those semi-indigents who are clearly proven by the records to be worthy of this type of charity and who, in accepting it shall be conscious of the fact that it is a charity on the part of the state to provide it and that it is not a service which they have a right to demand regardless of their proven economic status. We believe that it should be a cooperative service to the active practitioner but one that cannot be taken adantage of unjustly with unnecessary cost to the tax payers who have provided the building, equipment and personnel for its performance nor by unscrupulous practitioners of medicine, or by politicians. Your committee believes that this service primarily should be limited to such cases as require, but cannot procure, specialized service at their place of residence or in a readily accessible medical center.

The admittance of a patient to this service should only be obtained by the proper filling out of special admittance sheets,[9] on which would be kept clear and accessible records embracing among other things:

a. Signed statement by the referring physician.
b. Sworn statement by the applicant as to his financial condition.

[8] See Addendum No. V, page 2, after question 9.

[9] See Addendum No. VI for suggested forms.

c. Ascertainment in regard to possible help from his relatives.

d. A credit report for which the applicant shall pay $1 to be secured by an outside credit agency whose special report shall be kept in the individual file of the patient.

For the years 1929 and 1930, if the private patients are added to the Clinic cases, the percentage of non-indigent patients as compared with indigent county cases is as follows: (See table of tabulations, Addendum No. II, page 11).

	1929	1930
Private pay patients	20%	17%
Clinic cases	30%	27%
Total	50%	44%

In a compilation of State patients by counties admitted to the Wisconsin State General Hospital during the year 1929, tabulated through the office of the Secretary of the Society[10] with the elimination of all readmissions, there were 2,816 county cases admitted in the fiscal year July 1, 1929, to June 30, 1930.

The tabulation available to us through the Hospital authorities shows that in the year 1929[11] there were admitted as

Clinic cases	2,026
Private cases	1,325
	3,351

Or an apparent excess of 535 private and clinic admissions over indigent ones.

It is possible that the hospital tabulation included readmissions of private and clinic cases but your committee was not permitted access, through its auditors, to the necessary records to ascertain this.

It seems to your committee that this is a very high percentage indeed for an institution whose primary function ostensibly is to take care of the indigent sick and that there must be occasions when deserving indigent patients cannot possibly obtain service and that unless there be a change in policy, the situation will be aggravated in the future.

Findings—Private Patients

While the present and recent past constitutes a period of flux and experiment in the worthy effort of medical schools in the United States to arrive at a system of better medical education, many questionable procedures have been adopted which in the opinion of leaders in our profession are passing phases and destined to be discarded.

Your committee feels that the adoption by the Medical School of the University of Wisconsin of the policy of permitting members of the faculty to add undetermined sums of money each year to their incomes by use of state facilities is wrong and cannot continue without steady impairment of the friendly and cooperative relationship so essential between the Medical School and the active private practitioners of the state.

The arguments advanced for the necessity of this type of admission are, in the opinion of your Committee, unsound in principle and very questionable from an ethical standpoint.

While this policy may be applicable to private medical schools with private foundation support, it is so maintained solely because of the inherent power in such institutions to do as they wish regardless of the ethical questions raised thereby or the public interest.

For a great sovereign state such as Wisconsin to continue such a policy in the face of the undeniably unjust, unfair, and unequal advantage it acquires by so doing over a respectable contingent of its citizens simply because it has the power to do so is subversive of the ideal conception of the State as an exemplar of justice. The isolation of this group of private patients in private rooms makes their general use as clinical teaching material negligible.

The main reason for accepting them is plainly one of income. The argument advanced that the presence of private patients means a better type of care for the indigent patients is, in the opinion of your committee, not supported on fact as disclosed by the study of institutions devoted to care of the indigent.

If these same men were permitted to pursue a part time private practice only in institutions not owned and controlled by the state, devoting their proper time as servants of the state to the duties of teaching and the care of the indigent sick, receiving therefrom a proper and adequate salary, they would be in direct and fair competition with the rest of the profession which condition would be accepted as a matter of course.

An analysis reveals that the income of several of the incumbents of these staff positions has at times approached a condition wherein the fixed salary was much lower than the income derived from private patients.

Thus incumbent X:

	Salary	Net Fees	Total	Gross Fees	Apparent Overhead Expense
1930	$6,000	$8,705	$14,705	$8,995	$290
1931	6,000	9,421	15,421	9,825	404

Two year average: salary 39.8%; fees 60.2%.

Incumbent Y:

	Salary	Net Fees	Total
1927	$7,250	$12,045.00	$19,295.00
1928	7,500	12,852.28	20,352.28
1929	7,500	11,232.29	18,732.39
1930	7,500	9,473.37	16,973.37
1931	7,500	9,145.33	16,645.33

Five year average: salary 40.4%; fees 59.6%.

[10] See Addendum No. VII.
[11] See Addendum No. II, page 11.

In the opinion of your committee, there is no sufficient reason for the continuance of this type of service at the State of Wisconsin General Hospital.

In another state where the policy in effect is that of the state itself collecting and keeping the fees for private patients, the comments of the Special Committee of Investigation appointed by the State Medical Society are pertinent.

"This is 'State Medicine' for the sake of education, but nevertheless 'State Medicine' and there seems to be no sufficient reason for it. If the University Medical School and Hospital to which we look for the highest standards, not only in scientific medicine but as well in medico-social ethics, are receptive to such practice, into what depths of unsoundness may not the rest of us be induced to dip?"

A contention that has been advanced in the admittance of private patients to the Wisconsin General Hospital is that the University, as a servant of the State, has no proper right to refuse service to those able to pay. We are here concerned in such argument not with the present number of pay patients but a policy. Such a policy, carried on to logical conclusions, would necessitate provision at state expense of facilities for all who cared to use them. Such a policy has no line of demarcation as to numbers or services. We suggest that the University is erected by the taxpayers to serve the state not by selling at wholesale or retail to those citizens who have money enough to go to Madison, but to perform a singular function,—that of education.

Granted that it is the duty of the political unit to treat the indigent sick, it is not as yet, in the opinion of your committee, the business of the State to practice medicine for monetary return. That function has been delegated by the State to private practitioners, whom the state examines as to their qualifications, exercises control over them, and demands licenses of them before they may enter upon practice. It is within the province of the state through its educational facilities to educate students of medicine and grant them the requisite degree and post graduate instruction but there, we believe, its function constitutionally should stop.

To say that the state does not profit in a monetary way by its present plan of permitting members of the faculty of medicine to retain whatever fees they may gather from private patients hospitalized in public property and with the same breath to state that this is done because the state cannot afford to pay adequate salaries to certain of its educational employes simply begs the question and is beyond the understanding of your committee.

We accordingly enter the following recommendations:

1. That the substantial amount of room at the Hospital now reserved for the pay patients be allotted to the care of the state's wards,—the indigent.
2. That the University either employ its physicians as in Student Health Service,—on the full time basis, or at a salary for a part time service with permission to maintain separate offices and attend patients for fees in other Madison or outside institutions and hospitals as they may see fit in hours not under contract to the Hospital or Medical School. The latter provision will permit of an enlarged staff at a lesser cost to the state if that be the desire of the Hospital and Medical School.

(See Supplementary Report, page 1006)

Findings—Annual Reports

Under the state Hospital Law it would appear that rather a blanket authority has been given to the Hospital for the conduct of its affairs and that aside from state cases the law is not mandatory upon the hospital authorities. Presumably the Board of Regents have the primal authority and responsibility for the conduction of the institution and its policies.

Such being the case, your committee was amazed to learn from the auditors that apparently no annual report of the institution embracing all the factors which should be available in a public property has ever been compiled, the business manager of the University stating that a simple financial statement in regard to the position of the State of Wisconsin General Hospital was the only report made to the Board of Regents.

Other Conclusions

Your committee is of the firm belief that a proper, dignified presentation of these findings and recommendations before the ones primarily responsible for the policy of management and conduct of the State of Wisconsin General Hospital,—the Board of Regents, based on the conception that a united, sympathetic, cooperative profession will insure more than any other factor the future continuing success and reputation of the College of Medicine, will meet with proper attention and consideration.

The ranks of our profession in this state will in ever increasing numbers be filled as we pass on by graduates of the University of Wisconsin Medical School. We owe it our complete allegiance but feel that this should be based on a cooperative pride in achievement with mutual appreciation not only of the travail and mistakes inherent to the conception and birth of a great institution, such as a College of Medicine controlling its own hospital, but also of the fact that the state in conducting such an enterprise should concern itself to the utmost degree that it will not transgress or over-step rights and privileges properly assumed by virtue of its sovereignty.

1. Your committee feels that the study of the limited investigation of the Wisconsin General Hospital indicates that the state has been unwittingly recreant in (1) failing to ascertain and keep the public informed as to the actual facts in regard to the admission of patients to this hospital since its opening, and (2) in failing to publish a yearly report, such as other hospitals of this nature do.

2. Your committee suggests that the present committee be continued for the purpose of doing that which seems proper to carry into effect such of the recommendations as may be adopted by your House.

Respectfully submitted,

REGINALD H. JACKSON, M. D., *Chairman*,
GUNNAR GUNDERSEN, M. D.,
STEPHEN E. GAVIN, M. D.,
FRANK W. POPE, M. D.,
ROCK SLEYSTER, M. D.,
GREGORY CONNELL, M. D.,
JOHN YATES, M. D.,
THOMAS O'LEARY, M. D.,
DREXEL DAWSON, M. D.,
CARL DAVIS, M. D.,
JOSEPH DEAN, M. D.,
GEORGE CROWNHART.

SUMMARY OF FINDINGS

Special Committee of the State Medical Society of Wisconsin on Investigation of Admissions to State of Wisconsin General Hospital, 1932

The State Medical Society of Wisconsin was chartered in 1841 as a recognition of the public service that could be rendered by a single state-wide society of Wisconsin physicians. Its state charter is presently found as Chapter 148, Wisconsin statutes, and the Society now embraces some 2,150 physicians.

The Society was the first to suggest and secure enactment of laws creating institutional care of the insane and feeble-minded, general laws to protect the public health including those creating the State Board of Health (1875), care of the tuberculous, protection of the credulous sick from those who would prey upon them by fraud and deceit, and such other laws of public benefit as typified by that providing for the labeling as "Poison" lye for household use to prevent the then prevalent lye-poisoning of children. The present annual contribution of its members in services to the indigent and semi-indigent is in excess of $6,000,000 annually and the Society has long been concerned in solving those problems attendant upon providing an adequate care for the sick at a cost within their respective abilities to meet without depleting proper reserves for old age.

In the past fifty years the Society on several occasions has either proposed or lent its support to those measures looking to the creation and perfection of the Medical School at the University of Wisconsin. In its present study, the Society is but continuing the public interest it has long expressed in the Medical School and its facilities.

Creation of the Hospital

The State of Wisconsin General Hospital was authorized in the special session of 1920 as a teaching center for the four year medical course at the University, to be inaugurated upon its completion. The Hospital was opened in October, 1924 under Chapter 142, Wisconsin statutes. Financed by a transfer of a surplus in the soldier bonus fund, the institution was dedicated as a soldier memorial.

The statutes themselves specifically provide for two classes of patients:

a. The "public patient" to be admitted as a joint state and county charge upon application approved by the County Judge upon showing that the patient could probably be advantageously therein, and
b. The war veteran who shall be given preference in admittance at a single cost rate of $5 a day to cover hospitalization and medical or surgical service found essential.

The *regulations* of the Hospital, adopted upon its opening, provided for two additional classes of patients:

c. The private pay patient from whom the Hospital and attending staff physician collected full fees, and
d. The so-called "clinic case" defined as a patient "admitted upon the recommendation of a physician or of a responsible official with a statement that they can pay the cost of hospitalization but that a professional fee in addition would be a severe handicap."

Procedures at the Hospital

Since its opening, the Hospital has not made any published reports such as are usual in like institutions. In the mean time physicians have long suggested in meetings and individual communications that the institution, while rendering a fine service of a specialized nature to the public patient, was not fulfilling its complete function by reason of errors in admission of patients. Impressed with the increasing number of complaints and lacking any survey of the institution as a whole in its relation to the state and the teaching of medicine, the Council of the State Medical Society authorized this special committee to make such a complete study and report its findings to the 1932 House of Delegates of the Society. The Committee report which covers a large amount of detailed information, is summarized herewith as to its essential findings and recommendations.

Findings and Recommendations

I. The Public Patient.
   A. Findings.
      1. The public patients constituted but 65% of the admissions in 1931.
      2. Inasmuch as the Junior and Senior classes in the Medical School are limited in size, the state subsidy to the counties for the purpose of securing public patients as teaching material has been outgrown and is no longer essential.
      3. There exists no present need for enlarging the Hospital.

B. Recommendations.

1. Hospital authorities may well extend their efforts to educate referring officials as to the exact type of public patients desired as teaching material, and to point out that the Hospital is not intended to care, and cannot in fact care or attempt to care for either all of the public patients in the state or any substantial portion of them.

2. Local institutions for the care of the community sick must continue to be used for the general medical and surgical care of the indigent sick. They have in fact more than adequate room and facilities for such care. To offer state facilities with the attendant state subsidy in competition with adequate local facilities is not the function of the State Hospital. Continuance in any part can only result in unnecessary costs to the state and in increasing the costs of illness to the pay patients of the institution that is denied the public support it so well deserves. We urge that the Hospital authorities contact all referring officials that these fundamental principles be explained in detail.

II. The Clinic Case.

A. Findings.

1. The Clinic Case constituted 21% of the admissions in 1931.

2. The provisions for the clinic case are in fact provisions for the referred specialized care of the semi-indigent.

B. Recommendations.

1. A formal application blank should be prepared for certification by both the present family physician and the patient that the applicant is financially deserving of the state's facilities, to the end that the limited facilities provided shall not be used to satisfy the whims of the undeserving.

2. Inasmuch as the purpose of this classification is to provide a specialized care for those needing such treatment, the referring authorities should be those who are best in position to know that which is indicated. We recommend that only physicians be permitted to refer this type of case.

3. The Hospital, in the interest of conserving its resources for the deserving, may well make its own inquiries through a credit report, the cost of which ($1) shall be paid by the applicant.

III. The Private Case.

A. Findings.

1. Fourteen per cent of all admittances at the State Hospital during the calendar year of 1931 were for the 1,110 private patients.

2. Chiefs of services receiving upwards of $7,000 a year salary from the state, received an even larger amount from the care of private patients through the use of state facilities. The compensation of eighteen staff members regarded as essentially full time staff members was as follows for the year 1931:

From the state as salaries _____	$103,500.00
Received from private patients___	59,276.00

B. Recommendations.

1. Staff members should either be retained on a full time basis or (b) for a definitely outlined part time service with permission to treat private patients outside the State Hospital in hours not allotted to the state.

2. The substantial amount of floor space at the Hospital now devoted to private rooms for the care of private patients should be given over to the care of the indigent and semi-indigent.

(See Supplementary Report, page 1006)

It is our further recommendation that the Hospital publish an annual report similar to those published in like institutions elsewhere.

While your committee was appointed in April, 1932, its members and officers of the Society who are in unanimous agreement on these recommendations have given to the problem continuous observation and study for the years of the hospital establishment. All are of the opinion that the recommendations made herein will operate not only in the public interest but to the distinct advantage of the Medical School for the years to come.

Addenda

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No. I. Dean Bardeen's Communication to the Special Committee of the Dane County Medical Society in re so called clinic cases.
No. II. Report of Elwell & Kickhofer Certified Public Accountants on work done for Special Committee of the Wisconsin State Medical Society.
No. III. Correspondence of R. H. Jackson, Chairman, with Dr. Robert Buerki, Superintendent of the State of Wisconsin General Hospital.
No. IV. Letter from Dean Bardeen in re refusal to permit access to names of Clinic Cases.
No. V. Questionnaire sent to membership of Society with tabulated results of answers to certain questions.
No. VI. Suggestions for possible forms of blanks for application to semi-indigent clinic service.
No. VII. Tabulations of State County admissions to State of Wisconsin General Hospital 1929 and 1930, compiled through the office of the Secretary of the Wisconsin State Medical Society, with elimination of readmissions.

ADDENDUM NO. I

CLINIC PATIENTS AT THE WISCONSIN GENERAL HOSPITAL

Dean Bardeen's Report to Special Committee, Dane County Medical Society

At the request of Chairman Greeley, the hospital staff members of the committee appointed to consider the question of clinic patients at the hospital report as follows:

(1) The relative number of clinic patients at the hospital has been steadily decreasing. In the early years of the hospital it ran as high as twenty per cent. In 1930–31 it was 14.3 per cent. In 1931–32 it was 9.5 per cent. At present it runs about 8 per cent.

(2) Judging from the study of 100 consecutive cases reported by Mr. Crownhart at the last meeting of the House of Delegates and published in the December number of the Wisconsin Medical Journal and from a new study now under way, the large majority of the clinic patients are deserving of the care which they seek. A considerable number of them, however, should have been referred as State patients since they have not the means to pay for hospital care. Relatively very few have been found to possess means not entitling them from the economic standpoint for reference as clinic patients. Among the 100 referred to above, Mr. Crownhart found four such cases. Over a period of five years he found three such cases referred from Columbia County.

(3) It is recommended that the members of the society make use of the clinic service at the hospital only in such instances as the financial and clinical condition of the patient appear fully to justify such reference. At present the use of the service rests in the hands of the profession.

(4) The clinic service was established for three purposes:

a. Educational. Clinic patients are of value in medical teaching and study. This value is not, however, so great as to justify the retention of this service for this reason alone.

b. Professional. The services for clinic patients offers the family practitioner an opportunity to obtain for patients of limited means the aid of specialists in diagnosis and treatment which they might have to forego if this service were not available. The popular cry against the "high cost of medical care" is directed largely in the direction of this sort of care for this sort of patient. It is up to the family practitioner to make use of it or not as he deems to the best interest of the patient and of his fellow practitioners.

c. Social. In the act establishing the hospital it is stated "said hospital shall be more particularly designed for the care of persons afflicted with a malady, deformity or ailment of a nature which can probably be remedied by hospital service and treatment who would be unable otherwise to secure such care." From the social standpoint the public welfare demands healthy citizens. If an ounce of prevention is worth a pound of cure, a pound of medical care in time is worth a ton of prolonged custodial institutional care. For patients without resources to pay for special hospital care, the state patient service offers a means for obtaining this care. The state and county jointly pay for the hospital care. For patients without resources to pay for the services of specialists but with means to pay for special hospital care the clinic service offers a method of obtaining this care without cost to the taxpayer. In both instances clinical teachers provide the special medical care needed, as a part of their duties as teachers. The responsibility now rests with the medical profession to see that these opportunities are utilized to the best interests of patients, the public, and the profession. In the long run these interests are common interests. Cooperation will accomplish more than opposition.

(5) At present the initiative in use of the Clinic Service rests with the medical profession. In most public hospitals, including state university teaching hospitals, patients of a type similar to our clinic patients are received directly at the hospital. At public hospitals for the care of the insane and the

tubercular in this state, patients who can afford to pay full cost of hospital care are expected to pay no more even if they can afford fees to physicians. The taxpayer is interested in having necessary care given at as little personal cost as necessary. If the present clinic service as a service in cooperation with the family practitioner were "abolished", as called for in the resolution of the Columbus committee, there is reason to believe that there would be public pressure to throw the doors of the hospital open to all in need of hospital care able to pay for the costs thereof. The American Legion had legislation to this effect put through the legislature at the session before last with respect to ex-service men. To the credit of the Legion this legislation has not been abused. For the best interests of the profession as well as of the public it is important for the profession to take no action which will cause a public reaction detrimental to the best interests of all.

Comment by committee.*

ADDENDUM NO. II

REPORT ON CLINIC CASES

Wisconsin General Hospital
Madison, Wisconsin
June 14, 1932

Elwell, Kiekhofer and Company
Certified Public Accountants
Madison Milwaukee

Madison, Wisconsin, June 14, 1932.

Dr. R. H. Jackson, Chairman,
Special Committee on Admissions to Wisconsin General Hospital,
State Medical Society of Wisconsin,
Madison, Wisconsin.

Dear Dr. Jackson:

According to your instructions, we present herewith a report covering our investigation of admitting certain types of patients to the Wisconsin General Hospital. Your instructions were contained in three different letters, dated May 24, 1932, June 1, 1932 and June 6, 1932. The report upon each letter follows in order.

Report Upon Letter of May 24, 1932, Regarding Clinic Patients

"Elwell, Kiekhofer and Company,
Madison, Wisconsin.

Gentlemen:

Confirming our conversation of May 24, 1932, the committee appointed by the council of the Wisconsin State Medical Society to investigate the methods of admission of patients to the Wisconsin General Hospital wishes to employ your firm to make an independent and impartial examination to ascertain certain facts to be incorporated in the report of the committee to the House of Delegates. Dr. R. C. Buerki, superintendent of the Wisconsin General Hospital, assures me they will extend every courtesy and aid to you in this work.

For the present, the committee would like you to take up the so-called $5 per day clinic case and desire that your study include:

1. Total number of clinic patients of this type admitted last year, from January 1, 1931 to December 31, 1931, inclusive.
2. Source of these cases as to counties, with names of referring doctors.
3. Study of these as to whether the records justify the admission of each case according to the rules governing such admission at the Institution.
4. When, in your opinion, the record as to economic status of the patient does not clearly indicate that such patient was entitled to admission make note of it and ascertain as well as possible the true financial status of that particular patient at the time of admission. As this type of patient is admitted only by the certification by letter of a physician that it would be a financial hardship for the patient to pay more than this $5 a day fee, the great majority of such patients should unquestionably be found to have been properly admitted. If any cases were admitted without such a letter, please note it and request an explanation as to the reason.
5. Total number of these cases each year for the past five years admitted from Dane County, with names of referring doctors, or if not admitted by letters from physicians, a notation as to the reason.
6. A study of the method used in ascertaining the economic status of the patient before January 1, 1932, and of the method since then.
7. Number of cases admitted from January 1, 1932 to date of this examination.

Very truly yours,
R. H. JACKSON, *Chairman,*
Committee on Investigation."

In order to know the authority of the Hospital for having the so-called "clinic case" we referred to the statutes but found that no specific provision is made for this type of case. The statute relative to hospital charges reads as follows:

"142.07—Hospital charges. (1) The Wisconsin general hospital shall treat patients so admitted at rates based on actual cost as determined by the board of regents of the university. Payments made by such patients shall be credited to their accounts. Patients may be admitted without certificate, but the cost of their care shall not be a joint charge against the state and county wherein he has a legal settlement, except such patients are admitted in an emergency pending action of the county court. If

* There is no intimation that Clinic Cases can also be admitted by "responsible officials" without letter from physicians.

the court grants the application on the charges against state and such county shall date from his admission. An emergency shall include cases where, by reason of unforeseen physical conditions, a patient is detained in the hospital longer than anticipated and is thereby financially unable to bear the expense of treatment.

(2) No compensation shall be charged against or received from any patient by any officer of or person employed by the hospital other than the compensation provided by the board of regents of the university."

We learned that the hospital administration authorized the clinic case some years ago. The following paragraph appears in the "Summary of the Laws and Regulations relating to the Wisconsin General Hospital" published in 1925:

"Clinic patients are patients admitted upon the recommendation of a physician or of a responsible official with a statement that they can pay the cost of hospitalization but that a professional fee in addition would be a severe handicap."

Report Upon Instruction 1

"Total number of clinic patients of this type admitted last year, from January 1, 1931 to December 31, 1931, inclusive."

From the correspondence files beginning January 1, 1931 we checked the county-state and clinic cases through June 30, 1931. Out of a total of 2,158 cases included within this period (Case No. 53361 to 55518 both inclusive) there were 469 cases, or 21.73% entered as clinic cases. Acting upon your instructions, we did not complete the analysis for the balance of the year. (There were seventeen clinic cases included within the above range of case numbers which apparently were admitted in the last few days of July, due apparently to some confusion in the numbering or filing procedure. These cases had been studied before you ordered us to survey only the first six months rather than the entire year.)

The 469 clinic cases were distributed by months as follows:

January	57
February	65
March	75
April	80
May	83
June	92
July	17
Total	469

Although there are 2,158 numbers between Case No. 53361 and Case No. 55518 both inclusive, we found many files to be missing and were informed by the hospital authorities that the missing file numbers related to private patients. The analysis which we made of these file number filings for this period is as follows:

Case numbers to be accounted for	2,158
Folders in file reported by hospital authorities	1,769
Private patients during period	389

There were, therefore, the following numbers of the three types of patients—state, clinic and private—during this period:

Admissions—First Six Months, 1931

	Number	Per Cent
State	1,300	60.24
Clinic	469	21.73
Private	389	18.03
Total	2,158	100.00

The statistics which the hospital authorities prepared in response to the request in your letter of June 6, 1932, referred to hereinafter, shows that for the year 1931 the data relative to admissions were as follows:

Admissions—Year 1931

	Number	Per Cent
State	5,191	65.00
Clinic	1,672	21.00
Private	1,110	14.00
Total	7,973	100.00

Comparing these two sets of figures and percentages, it is apparent that the number and per cent of clinic patients for the last six months of 1931 ran about the same proportion as for the first six months, but that the number and percentage of private patients declined in proportion to the number and percentage of state cases.

Report Upon Instruction 2

"Source of these cases as to counties, with names of referring doctors."

We found that the Hospital has no record of clinic cases by counties, and since the names of the counties do not appear in the correspondence or on the folder, it would mean that we would have to look up the county in which each village, town or city, was located before we could give you this information. When we advised you of this situation, you will recall you told us not to spend any time in ascertaining these data.

As to the names of the doctors, Dean Bardeen and Dr. Buerki objected to reporting them to your committee. This was one of the points covered in a letter written you by Dean Bardeen on May 28,

1932 (copy of which was given us) in which the matter is referred to as follows:

"While we have permitted him to list patients by number under the name of the referring physician, it is with the understanding that the use of the name of the referring physician is an impersonal one for the confidential convenience of Mr. Elwell and that in any report prepared by Mr. Elwell the physician will be referred to by number, not by name."

Complying with this restriction placed upon us by Dean Bardeen we report that of the clinic cases sent in by doctors there were:

128	doctors referring	1 case
42	doctors referring	2 cases
3	doctors referring	4 cases
8	doctors referring	5 cases
2	doctors referring	6 cases
2	doctors referring	7 cases
2	doctors referring	8 cases
1	doctor referring	9 cases
188	doctors referring	396 cases

Of the 469 clinic cases, we find that 29 were admitted through other than physicians. The list of such admissions is as follows:

Poor Commissioner	6
County Judge	4
Chairman, Town Board	3
Public Health Nurses	2
Attic Angels	2
Registered Nurses	2
Social Worker	2
County Nurse	1
Police Department	1
Board of Control	1
Industrial Commission	1
Assemblyman	1
Ex-Assemblyman	1
State Senator	1
Secretary, one of State Boards	1
Total	29

We also find that 16 cases, or 3.41% were those of employees or relatives of employees.

There were 10, or 2.13%, emergency cases for which state papers were asked for and received.

There were 9, or 1.92%, emergency cases for which state papers were asked for and not received.

There were 22, or 4.69% of general emergency cases arising largely from accidents.

One of the definitions of a "clinic case" which is frequently used is

"A clinic case is one sent to the hospital by a physician with a letter stating that the patient can pay the $5 per day for hospitalization but that a professional fee in addition would be a hardship."

This is practically the definition of this type of patient given in your instruction number 4, quoted above.

There were 39, or 8.32% of the total clinic cases surveyed where there was a letter from the doctor but no reference was made in it as to the basis of admission.

There were 17, or 3.62%, of the cases in which no reference was made as to the basis of admission in the letter, but where the admission as a "clinic case" was verified by telephone.

There were 47, or 10.02% of the cases for which there was no letter, note or other comments from the doctor.

Summarizing these three groups just given above:

Group	Number	Per Cent
1. Letters but no reference to basis of admission	39	8.32%
2. No reference to basis of admission but verification of clinic basis by telephone	17	3.62%
3. No letters or notes	47	10.02%
	103	21.96%

it appears that of the 469 clinic cases surveyed, 103 cases or 21.96% were *not* "sent to the hospital by a physician with a letter stating that the patient can pay the $5 per day for hospitalization but that a professional fee in addition would be a hardship". Of these 103 cases, 47 had no letters whatsoever and 56 (39 plus 17) had letters which contained no reference to the basis of admission. The hospital authorities state that they discuss the financial condition of the patient with him and that in this way they determine which ones are to be "clinic cases".

Of the above 103 cases, 17 were cases which later became county-state cases, but it is the practice of the hospital to admit these patients as "clinic 'til" the state papers are received.

There were, therefore, 86 of the 469 cases, or 18.3% which were admitted as clinic without the required statement, and which remained clinic. We have no explanations as to the reason for admitting clinic patients without the letters other than the hospital authorities state that they discuss the financial situation with each patient and that in this way they determine the clinic basis.

We are unable to report upon the economic status of the clinic patients, because the authorities would not permit us to take down the names of the patients. Without these names, we obviously could not make an investigation of the financial standing of the clinic patients. Dean Bardeen's letter of May 28 to you stated the above fact when he said ". . . We have permitted Mr. Elwell to go over the record of clinic patients, listing each by number instead of by name".

Report Upon Instruction 5

"Total number of these cases each year for the past five years admitted from Dane County, with names of referring doctors, or if not admitted by letters from physicians, a notation as to the reason."

When we reported orally to you that there is no record kept of clinic cases *by counties*, you instructed us not to attempt to ascertain the number of Dane County cases each year for the past five years. These data could be obtained only by going through the files (as we have done for the first six months of 1931) and tabulating those cards coming from towns in Dane County.

Report Upon Instruction 6

"A study of the method used in ascertaining the economic status of the patient before January 1, 1932, and of the method since then."

As previously stated, the clinic patient is supposed to have a letter from his physician approving admission as a clinic case. In those cases where no letter has been written or no reference is made to the basis of admission the authorities discuss the financial status of each patient with him and determine whether the clinic basis is a proper one.

The hospital authorities state that they are giving closer attention to the clinic case group, that they have a social worker and are making more careful investigation as to the financial ability of each prospective clinic patient. Dr. Hockett, Admitting Officer, is now compiling data on 100 current clinic cases (78 were completed at the time of this study). An analysis of these cases might well be made when the entire study is completed.

Report Upon Instruction 7

"Number of cases admitted from January 1, 1932 to date of this examination."

We would be able to report upon the number of clinic cases admitted this year to date only by going through the files and tabulating the clinic cases. This you did not think necessary. The hospital authorities report that for the first five months of 1932 the number and per cent of patients were as follows:

Admissions—First Five Months, 1932

	Number	Per Cent
State	2,696	76%
Clinic	505	14%
Private	367	10%

Report Upon Request of June 1, 1932 Regarding Private Patients

Your letter of June 1 to Dr. Buerki on this matter was as follows:

"June 1, 1932.

Dr. R. C. Buerki,
State of Wisconsin General Hospital,
Madison, Wisconsin.
Dear Dr. Buerki:

The committee appointed by the Council to investigate the admission of the three types of patients to the State of Wisconsin General Hospital to report to the House of Delegates respectfully requests that if it is possible to do so, you would permit Messrs. Elwell and Kiekhofer to ascertain the following facts in regard to private patients.

1. Total number of private hospital patients each year for the past five years.
2. Source of, as to counties.
3. Percentage referred to the Institution by its own staff members.
4. Percentage referred to the Institution by non-staff members.
5. Number of private patients or percentage of private patients not given bills or where hospital bills were cancelled and list of such cases as to vocations.

I wish to assure you that the committee will appreciate to the full such cooperation as will permit the committee to ascertain the answers to these questions which were unanimously agreed upon by the committee as essential to their investigation.

Very truly yours,
R. H. Jackson, M. D.,
Chairman, Committee of Investigation."

We called at Dr. Buerki's office ready to begin work upon this engagement but were informed by him that he would be unable to allow us to do such work without consulting the staff surgeons who engage in private practice. He further stated the hospital was merely acting as agent for these gentlemen and that he therefore could not open the private patient files to us. He was to inform either you or us later as to their position in the matter and I believe he has advised you by letter that permission to make such an investigation of private patients must be obtained from the Board of Regents.

Report Upon Request of June 6, 1932 Relative to Hospital Population

"June 6, 1932.

Dr. R. C. Buerki,
State of Wisconsin General Hospital,
Madison, Wisconsin.
Dear Dr. Buerki:

The special committee appointed by the Council of the Wisconsin State Medical Society would greatly appreciate a tabulation of the daily hospital population for 1931 in the State of Wisconsin General Hospital, such tabulation to show the relative proportion of each class of admissions.

We are requesting the firm of Elwell and Kiekhofer to procure these figures from you and presume that you have on file such a record of admission so that this request can be readily and easily complied with.

Thanking you on behalf of the committee for your cooperation, I remain

Sincerely yours,
R. H. Jackson, M. D.,
Chairman, Committee of Investigation."

In response to this request the hospital authorities have furnished us with the following statistics covering the past five years. In accordance with your oral instructions to us, they are included in this report without any attempt upon our part to verify them.

The statistics relative to admissions for the past five years appear as Exhibit I; the statistics relative to patient days appear as Exhibit II; and a detailed analysis of patient days for the years 1931 and 1932 as Exhibit III.

A summary of Exhibits I and II by types of patients appears as follows:

Percentages of Clinic Patients

	1927	1928	1929	1930	1931
Admissions	32%	31%	30%	27%	21%
Patient Days	16%	16%	16%	15%	10%

Percentages of Private Patients

	1927	1928	1929	1930	1931
Admissions	24%	22%	20%	17%	14%
Patient Days	9%	9%	8%	8%	6%

Percentages of State Patients

	1927	1928	1929	1930	1931
Admissions	44%	47%	50%	56%	65%
Patient Days	75%	75%	76%	77%	84%

From the above data it is apparent that considerable confusion results from referring to percentages of types of patients without specifying whether the base of such percentages is either *admissions* or *patient days*. The statistics which we have seen in type and in letters relative to percentages of patients, such as for

	1930	1931
State	77	84
Clinic	15	10
Private	8	6

are supported by Exhibit II as referring only to the patient day basis, not to admissions.

We wish to take this opportunity of thanking Dean Bardeen and Doctors Buerki and Hockett for their cooperation in making this report.

We should be pleased indeed to confer with your committee at any time regarding any of the points included in this report.

Respectfully submitted,
ELWELL, KIEKHOFER & CO.,
Certified Public Accountants.

NUMBER AND PERCENTAGE OF ADMISSIONS OF STATE, CLINIC AND PRIVATE PATIENTS

Compiled by the Hospital Authorities

	1927		1928		1929		1930		1931		1932*	
Admissions	Number	Per Cent	Number	Per Cent	Number	Per Cent	Number	Per Cent	Number	Per Cent	Number	Per Cent
State	2,350	44%	2,955	47%	3,302	50%	3,957	56%	5,191	65%	2,696	76%
Clinic	1,688	32%	1,958	31%	2,026	30%	1,882	27%	1,672	21%	505	14%
Private	1,272	24%	1,334	22%	1,325	20%	1,236	17%	1,110	14%	367	10%
Total	5,310	100%	6,247	100%	6,653	100%	7,075	100%	7,973	100%	3,568	100%

* The year 1932 includes only the first five months—January to May, inclusive.

NUMBER AND PERCENTAGE OF PATIENT DAYS OF STATE, CLINIC AND PRIVATE PATIENTS

Compiled by the Hospital Authorities

	1927		1928		1929		1930		1931		1932*	
Patient Days	Number	Per Cent	Number	Per Cent	Number	Per Cent	Number	Per Cent	Number	Per Cent	Number	Per Cent
State	90,295	75%	96,175	75%	99,774	76%	113,341	77%	147,172	84%	77,599	88%
Clinic	18,612	16%	20,787	16%	21,768	16%	22,338	15%	17,852	10%	7,037	8%
Private	11,284	9%	12,350	9%	10,992	8%	12,083	8%	10,876	6%	3,621	4%
Total	120,191	100%	129,312	100%	132,534	100%	147,762	100%	175,900	100%	88,257	100%

* The year 1932 includes only the first five months—January to May, inclusive.

PATIENT DAYS BY MONTHS

Compiled by the Hospital Authorities
Year 1931

Patient Days	January Pat. Days	January Av. Pat. per Day	February Pat. Days	February Av. Pat. per Day	March Pat. Days	March Av. Pat. per Day	April Pat. Days	April Av. Pat. per Day	May Pat. Days	May Av. Pat. per Day	June Pat. Days	June Av. Pat. per Day
State	10,423	336	9,703	347	11,560	373	10,859	362	10,447	337	12,341	411
Clinic	1,375	44	1,155	41	1,417	46	1,482	49	1,496	48	1,645	55
Private	983	32	833	30	902	29	939	31	744	24	999	33
Total	12,781	412	11,691	418	13,879	448	13,280	442	12,687	409	14,985	499

	July		August		September		October		November		December	
State	13,089	422	13,134	424	12,744	425	14,570	470	13,958	465	14,344	463
Clinic	1,706	55	1,770	57	1,433	48	1,762	57	1,327	44	1,284	41
Private	1,099	36	1,038	33	1,104	36	677	22	752	25	806	26
Total	15,894	513	15,942	514	15,281	509	17,009	549	16,037	534	16,434	530

Grand Total 1931

	Total Pat. Days	Av. Pat. per Day	Per Cent
	147,172	403	84
	17,852	49	10
	10,876	30	6
Total	175,900	482	100

Year 1932

	January		February		March		April		May		June
State	15,038	485	14,761	509	15,863	512	15,651	522	16,286	525	
Clinic	1,530	49	1,477	51	1,376	44	1,420	47	1,234	40	
Private	694	22	648	22	651	21	745	25	883	28	

Grand Total 1932

	77,599	511	88
	7,037	46	8
	3,621	24	4
Total	88,257	581	100

ADDENDUM NO. III

May 27, 1932.

Dr. R. C. Buerki, Superintendent,
State of Wisconsin General Hospital,
Madison, Wisconsin.

Dear Mr. Buerki:

As you know, Mr. George Crownhart, secretary of the State Medical Society, recently notified you and Dr. C. R. Bardeen by letter that at the meeting of the Council of the Society held at Milwaukee a special committee consisting of Dr. Gunnar Gundersen of La Crosse, Dr. Stephen Gavin of Fond du Lac, and Dr. Frank Pope of Racine, with myself as chairman, was appointed to investigate thoroughly the methods of admission of patients to the Wisconsin General Hospital and report to the House of Delegates, the report to be published in the Wisconsin State Medical Journal sixty days before the annual meeting in September.

The committee, before accepting the appointment, requested that a sufficient sum of money be allotted the committee to supply auditors to make an independent examination when desired in order to ascertain facts to be incorporated in the report to the House of Delegates. I understood from my conference with you and Dr. Hockett on the morning of May 24 and with you and Dr. Bardeen on the morning of May 27, that you would extend every courtesy and aid to Messrs. Elwell and Kiekhofer, certified public accountants, engaged by the committee to help

them in their investigation. For the present, the committee wishes to take up the so-called $5 a day clinic case which the committee understands is defined as "a patient admitted by a letter from a physician stating that the patient can pay the cost of hospitalization ($5 a day) but that a medical, surgical, or special diagnostic fee would be a 'financial hardship'." In regard to this type of admission the committee respectfully requests and has instructed Messrs. Elwell and Kiekhofer to obtain with your cooperation, the following information:

1. The total number of clinic patients of this type admitted last year from January 1, 1931, to December 31, 1931.
2. Source of these cases as to counties, with names of referring doctors.
3. Study of these as to whether the records justify the admission of each case according to the rules governing such admission at the Institution.
4. When, in their opinion, the record as to economic status of the patient does not clearly indicate that such patient was entitled to admission make note of it and ascertain as well as possible the true financial status of that particular patient at the time of admission. As this type of patient is admitted only by the certification by letter of a physician that it would be a financial hardship for the patient to pay more than this $5 a day fee, the great majority of such patients should unquestionably be found to have been properly admitted. If any cases were admitted without such letter, please note it and request an explanation as to the reason.
5. Total number of these cases each year for the past five years admitted from Dane County, with names of referring doctors, or if not admitted by letters from physicians, a notation as to the reason.
6. A study of the method used in ascertaining the economic status of the patient before January 1, 1932 and of the method since then.
7. Number of cases admitted from January 1, 1932 to date of this examination.

Thanking you in behalf of the committee for the cooperation so essential in arriving at an impartial analysis of the methods of admission of the different types of patients to the Wisconsin General Hospital, I remain

Sincerely yours,
R. H. JACKSON, M. D.,
Chairman, Committee of Investigation.

May 28, 1932.

Dr. R. C. Buerki, Superintendent,
State of Wisconsin General Hospital,
Madison, Wisconsin.
Dear Dr. Buerki:

In order that there shall be no possible misunderstanding and that my records as chairman of the committee appointed by the Council to investigate the methods of admission of patients to the Wisconsin General Hospital shall be clear, I wish you would confirm by letter my understanding of the development of yesterday afternoon as conveyed to me by telephone conversation with you and Dr. Bardeen. Namely, that the understanding which we arrived at yesterday morning in conference with Mr. Elwell to the effect that wherever the records of a so-called $5 a day clinic case failed to show that the patient had been correctly admitted in accordance with the definition and specified methods of admittance of this type of case (as given by you before the meeting of the County Society Secretaries last year) an effort should be made by Messrs. Elwell and Kiekhofer to ascertain by a credit report the true financial status of the patient at the time of admission, and also to make note of any other errors of admission—i. e., failure on the part of the Hospital records to show reasonable compliance with the specified requirements for this class of case.

In our telephone conversation, you stated and Dr. Bardeen confirmed your statement, that the committee could not obtain the names of any of these patients, that you were informed by Mr. Dan Grady that it would be illegal to allow this, and that the only cases which our committee could investigate would be those against whom specific complaints had been made by members of the Society; that when I asked how the former investigation conducted by Mr. George Crownhart, Secretary of the Society, had been carried out, you stated that he had investigated only cases in which specific complaints had been made. I would also greatly appreciate it if you would give me the reference to the specific statute on which this refusal to permit the committee to investigate any questionable case is based.

Sincerely yours,
R. H. JACKSON, M. D.,
Chairman, Committee of Investigation.

ADDENDUM NO. IV

The University of Wisconsin
Madison

May 28, 1932.

Dr. R. H. Jackson,
Chairman Special Committee of State Medical Society to investigate the Question of Clinic Cases at the Wisconsin General Hospital.
Madison, Wisconsin.
Dear Dr. Jackson:

At the conference held Friday, May 27, 1932, at the Wisconsin General Hospital attended by you and Mr. Elwell, Dr. Buerki, Dr. Hockett and me, you requested that Mr. Elwell be given access to the hospital records relating to clinic cases. You showed me a letter of instructions written to Mr. Elwell stating what the committee desired him to do and I requested a formal request written along similar lines either to Dr. Buerki or me asking for permission for Mr. Elwell to proceed as directed. This you agreed to do and meanwhile, since Mr. Elwell was ready for work, we agreed to let him

proceed along lines we felt authorized to grant. From your telephone conversations last night, I judge that you felt that greater freedom in the use of names should be given than we felt authorized to grant. In order to clear up misunderstanding so far as possible I am writing this letter in advance of receiving the formal request for access to hospital records referred to above.

We desire to cooperate to the full extent of our authority with your committee. Hospital records are regarded as coming within the provisions of the statutes relating to privileged communications between doctor and patient. Just how far one may disclose them to those not immediately concerned with the care of the patient is a question of authority and interpretation. Dr. Buerki is subject to the authority of the Hospital Executive Committee and to me as chairman of that committee. The Hospital Executive Committee is subject to the President of the University and to the Board of Regents. The Board of Regents has final authority. Where delicate questions of interpretations of the statutes are involved those in immediate authority have to pass the matter up to those in higher authority before a final decision can be reached. When your formal request for inspection of hospital records has been received, any part of this request those in immediate authority do not feel authorized to grant will, if you desire, be referred to the Board of Regents for final decision.

Those in immediate authority at the hospital feel authorized to examine into and report upon any complaints or charges relative to specific patients or to physicians misusing hospital service. We do not feel that in doing this we are in any way betraying professional confidence. We shall therefore be glad to cooperate with your committee in looking into any such cases as may come to your attention.

Those in immediate authority feel authorized to make impersonal use of hospital records for statistical purposes so long as the professional confidence of neither patients nor referring physicians is thereby involved, but not in such a way as might lead to a charge of betrayal of such confidence. For this purpose we have permitted Mr. Elwell to go over the records of clinic patients, listing each by number instead of name. While we have permitted him to list patients by number under the name of the referring physician, it is with the understanding that the use of the name of the referring physician is an impersonal one for the confidential convenience of Mr. Elwell and that in any report prepared by Mr. Elwell the physician will be referred to by number, not by name.

In order to make sure of my understanding of this question I took it up with Mr. Grady at the meeting of the executive committee of the Board of Regents yesterday afternoon and he confirmed my understanding.

Yours very sincerely,

C. R. Bardeen,
Dean.

ADDENDUM NO. V

QUESTIONNAIRE

To Each Member of the Wisconsin State Medical Society.

From the Special Committee appointed by the Council April 23, 1932, to investigate and report to the House of Delegates on the methods of admitting patients to the State of Wisconsin General Hospital. Dr. Gunnar Gundersen, La Crosse; Dr. Stephen E. Gavin, Fond du Lac; Dr. Frank W. Pope, Racine; Dr. Reginald H. Jackson, Madison, *(Chairman).*

While it is not within the function of the membership of the Society to direct the policy controlling the admission of patients to the State of Wisconsin General Hospital, their cooperation is essential to materially enhance the efficiency of this institution and to prevent a progressive impairment or vitiating of the function which it was professedly designed to fulfill, the care of indigent sick and to provide patients as teaching material for students of medicine.

So intimately interwoven are the problems of the State of Wisconsin General Hospital with the welfare of the College of Medicine that practically all problems pertaining to either embrace both. The history of medicine reveals that a College of Medicine, to achieve enduring distinction and success, must have the sympathetic cooperation of the active practitioners of medicine. It also shows that the profession of medicine as a whole has suffered its greatest injuries whenever there has been a division in the ranks. Never before in the history of our beloved profession has it been more important to present a united front. Assailed on every side by adverse, often unfair and at times hostile, criticism, needlessly suffering in an ever increasing way from social economic adjustments because we fail, as a profession, to take a united, enlightened, and guiding interest in them.

With these thoughts in mind, the committee appointed to investigate the admission of patients under the three classifications, first, so-called $5-a-day clinic case; second, private patients; and third, county patients, was at once confronted with the unequivocal fact that a major division is in the actual process of development in the medical profession of Wisconsin—a medicosocial economic revolt embracing many active practitioners of medicine who assert their rights as citizens, taxpayers, and competitors in the struggle for a livelihood to complain of and seek redress for certain injuries which they attribute to the policy directing and controlling the activities and conduct of the State of Wisconsin General Hospital.

While the question of the alleged abuse of the admittance of this or that type of patient assumes a minor aspect when considered alone, the rapidly developing cleavage in the ranks of the profession with its attendant rancor presents a major problem, one which will inevitably lead to further misunderstanding, distrust, and mutual harm if not rectified.

To project an internecine conflict too hastily into the legislature might conceivably be regrettable.

In the sincere belief that proper thought guided by the spirit of compromise and adjustment will lead to harmonious solution of the problems presented and eventuate in enduring benefit to the College of Medicine and the active practitioners of medicine, your committee has prepared the following questionnaire, the tabulated results of which will be a guiding factor in the recommendations presented to the House of Delegates.

It is the imperative duty of every member as well as an obligation to his professional brothers to clearly and frankly voice his opinion on every question.*

So-Called $5.00 a Day Clinic Case

Definition: A patient admitted by a letter from a physician stating that the patient can pay the cost of hospitalization ($5 a day) but that a medical, surgical, or special diagnostic fee would be a "financial hardship."

Advantages and arguments advanced for this class:

1. May be used in teaching medical students.
2. Justifiable benefaction bestowed on semi-indigents.
3. Cooperative diagnostic value to physicians without adequate facilities.

Objections offered by active practitioners:

1. The physician often is not in a position to accurately estimate the true financial condition of the applicant.
2. Refusal on the physician's part to grant the necessary letter results in the future ill will of the applicant, his family and his friends.
3. From past experience there is a prospect that a competitor will provide the requisite letter.
4. The active practitioner has noted an ever increasing tendency among his clientele (as they learn of this type of service from neighbors who have experienced it) to demand it as their right as tax-payers or citizens.
5. Attempted explanations by the active practitioner only "get him in wrong."
6. Charges are made that unscrupulous practitioners may arrange (for a fee) to admit patients under this classification so that the patient will obtain a necessary operation free aside from what they have arranged to pay the referring practitioner.
7. That it is leading to a great deal of friction and ill feeling.
8. That the term "financial hardship" is subject to different interpretations by different individuals.
9. That evidence is available of patients having had the benefits of this service who were in a financial position to remunerate private practitioners for such services. These instances are directly due to the physician who gives the necessary letter to the patient and are not the fault of the institution.

Would it, in your opinion, be to the best interest and continuing welfare of the Profession as a whole and the public to recommend the continuance of this class of admission to the State of Wisconsin General Hospital?

Yes	No	
109	501	1

Private Patients

Definition: One who pays full rates for all hospital service received, professional service directly remunerated to physician or surgeon who renders it to the patient.

Advantages and arguments advanced for:

1. Having a certain number of private patients in the hospital helps to insure a better kind of care for the charity patients.
2. The number of private patients is not limited arbitrarily but by "general understanding" to such a number as will not interfere with the primary duties of care of indigent patients, teaching and research.
3. Permits the state to obtain higher type surgeons and physicians for the faculty than would be the case if the emoluments and remunerations of private patients were denied them. Presumably, heretofore, the State of Wisconsin could not afford to pay for high class men.

Objections offered by active practitioners:

1. Physicians in charge may use state property and facilities to their own pecuniary advantage.
2. They might, by making their fees relatively low, build up a private practice into which they could step in a few years, whereas it would take many years to do this otherwise.
3. They might be directed by politically minded superiors to accept as private patients a very high percentage of so-called courtesy patients, no bill being presented, leaving a potential quid pro quo situation.

In your opinion, would it be beneficial to the continuing welfare of the Profession as a whole and the public if:

1. All chiefs and assistant heads of departments whose primary function is the instruction of medical students were placed on a definite, fixed, adequate salary and devoted their entire time to instruction and the care of teaching material patients in the State of Wisconsin General Hospital?

Yes	No	
574 79%	160 21%	2

* In answering questions, place X in "yes" or "no" column and write plainly in others, using ink.

	Yes	No	
2. If part time staff and faculty members whose primary interests are in their private practice were not permitted to have private patients in the State of Wisconsin General Hospital?	601 84%	113 16%	3
3. If patients who come under the compensation law aside from state employes, were not admitted to the institution except as emergency accident cases?	669 92%	56 8%	4
4. If the staff members were not permitted to do more than give first aid and emergency care to accident cases, all such cases, aside from indigent ones, to be transferred to other hospitals after emergency care?	632 90%	77 10%	5

County Cases

Definition: Indigent county cases admitted through the instrumentality of the county judge and the certification by a physician that the patient will presumably be benefited by the care of the institution. The hospital charge is:_____$4.76 per day
of which the State pays_____ 2.38 " "
and of which county pays_____ 2.38 " "
plus the charge of transportation, attendants on trip, etc., to and from the institution.

Advantages and arguments advanced for:

1. Necessary in the social economic welfare of the state.
2. Provides patients for instruction of medical students.

Objections raised by active practitioners:

1. If carried to extremes it will deprive them in an ever increasing way of the however slight remuneration they have received in the past for the relief of the local indigent-sick.

Questions

(To determine amount of nonremunerated professional service our membership renders society in an average year)

1. Are you engaged primarily in: (place × in appropriate square	Yes	No	
Active practice			
Service of State			
Federal service			6
Special Health organization, etc.			

2. How much professional work (indigent patients) did you do in 1931? (Computed on fair basis considering the type of patient) _____ $_____ 7
3. How much did you receive in money for it from any or all government sources? (Town, County or State) $_____ 8
4. How much such charity work did you do in 1928?_____ $_____ 9
5. How much did you receive for it? _____ $_____ 10
6. Aside from this, how much professional work did you do in 1928 for which you received no remuneration and now consider permanently uncollectible? _____ $_____ 11
7. What percentage of professional work do you average each year which is not remunerated in any way by society? _____ %_____ 12
8. What sum has this amounted to in an average year of your practice? (Compute average from good and bad years) _____ _____ 13
9. How many years have you been in practice? _____ _____ 14

	Yes	No	
10. From your experience, are you satisfied with the method of administration of the laws for relief of the indigent sick in this state?	110 15%	618 85%	15
11. Do you believe that the State should erect and conduct in various parts of the state more hospitals similar to the State of Wisconsin General Hospital for the care of the indigent sick?	45 6%	707 94%	16
The State of Wisconsin General Hospital is overfilled at present. If the depression continues and this condition persists, do you think the overload should be distributed among existing hospitals of a standard as to construction, equipment and professional staff comparable to the State of Wisconsin General Hospital?	710 93%	49 7%	17
Do you think that such standardized hospitals are entitled to ask that they be paid the same per diem charge that the State of Wisconsin General Hospital receives?	708 95%	38 5%	18

	Yes	No	
If the institutions render the same type of service including laboratory and special diagnostic service for these patients, and continue to receive only one-half as much as the State of Wisconsin General Hospital per patient, do you think it to the best interests of the profession as a whole that the State of Wisconsin should build up an appreciable surplus by its management of this institution?	151 23%	515 77%	19
Do you believe that if state aid to the State of Wisconsin General Hospital were abolished and the entire cost of care—i. e. $4.76 per day — were chargeable to the county referring the patient, it would eliminate the present injustice to the local or home town Hospitals?	564 77%	164 23%	20
If you answer NO, do you believe that a change in the rates (at present one-half by the county referring the patient and one-half by the state) to that which applies at present for county tuberculosis sanatoria, which receive $1.00 state aid per day would be advantageous?	126 51%	118 49%	21

If you have any constructive suggestion, comments, criticism, please write them plainly and express them clearly in this space.

Signature _____M. D.
(Desirable but not essential)

Member of _____County Med. Society.
(Necessary)

To be of any assistance to the Committee, questionnaire must be filled out and returned by June 15th.

ADDENDUM NO. VI

Section 142–01 of the Wisconsin Statutes referring to the public patient (indigent) at the State of Wisconsin General Hospital, defines an indigent to be one where "he or the person liable for his support is financially unable to provide proper treatment."

As one who can pay $5 per day is not an indigent, we believe there should be some guiding rules for the determination of that social economic status which will entitle an applicant to apply for admission to the semi-indigent service—if and when beds are available.

We believe that a special credit and social status blank should be devised by the proper authorities which would make it possible for the hospital officials to promptly and properly admit or reject a given application without jeopardizing the interest of the applicant or the public. We will favor a broad, liberal social policy adopted in the interpretation of information in regard to the age of the individual, the nature of the ailment, its probable duration, the number of dependents, and other social factors bearing upon the question of the applicant's ability to pay.

APPLICATION FOR SEMI INDIGENT CLINIC SERVICE AT THE STATE OF WISCONSIN GENERAL HOSPITAL

Statement by referring physician

I _____ M. D., a duly licensed physician of the State of Wisconsin, practicing at _____ _____ County, hereby affirm

I. That Mr (s) _____ residing at _____ _____ Co., is under my professional care at present and that the ailment with which she/he is afflicted is one which requires special diagnostic or therapeutic measures such as are provided at the State of Wisconsin General Hospital.

II. That the economic status of this patient or those legally responsible for her/him is to my best knowledge and belief such that she/he should be properly classed as a semi-indigent—meaning that in my opinion she/he is not financially able at the present time, nor is there a fair prospect that she/he will be able to raise in the near future, either through collateral borrowing or other credit arrangements, the necessary sum of money to procure these measures of diagnosis and possible relief elsewhere than at the State of Wisconsin General Hospital, without its being a "financial hardship" within the meaning of this term as outlined by the proper authorities for the semi-indigent service.

I hereby request and recommend that she/he be admitted to the State of Wisconsin General Hospital as a worthy applicant for the semi-indigent clinic service.

Date _____
Signed _____ M. D.
Residence _____Co.

Statement by Applicant

I _____ of _____ _____ County, being duly sworn, affirm that the foregoing statement of my attending physician has been read to me and that I understand that in making application for this service provided for semi-indigent patients I do so with the affirmation that it would be such a financial hardship for me to raise the money necessary to procure the special

services deemed necessary in my case by my physician elsewhere than at the State of Wisconsin General Hospital, that I could not obtain them.

I hereby agree:

1. In case my application is not accepted that the $1 fee sent in with my application shall be retained by the Hospital authorities as payment for the credit report of my economic status which I understand is necessary for the file of each patient in this service.

2. In case my application is accepted, I agree that the $1 fee shall be applied to the above mentioned credit service.

3. That I shall be freely used as clinical teaching material by the members of the teaching faculty of the Institution.

State of Wisconsin General Hospital—Data on Special Semi-Indigent Patient Service

No.____ Name_____ Residence_____ Co.____
Application Received _____
Referring Physician _____ _____ _____
Credit Report Justifies / Does not Justify Admission.

_____
Sig. of Superintendent
Action_____ Pt. accepted_____ Rejected_____
Admitted _____ Discharged_____
This patient was / was not used as clinical material for teaching purposes on my service.
Signature of Teacher _____ M. D.

ADDENDUM NO. VII

THE NUMBER OF STATE PATIENTS, BY COUNTIES, ADMITTED TO THE WISCONSIN STATE GENERAL HOSPITAL DURING THE LAST TWO YEARS

During the fiscal year of July 1, 1929—June 30, 1930 there were 2,816 state patients admitted to Wisconsin General Hospital. The County share as charged by the state (not including travel, attendants, etc.) amounted to $249,669.28.

During the fiscal year of July 1, 1930—June 30, 1931 there were 3,397 state patients admitted to Wisconsin General Hospital. The County Share amounted to $283,246.53.

The number of patients by years and counties with amount of the county share follows:

	Number of Patients		County Share at $2.38 Per Day	
	1929–30	1930–31	1929–30	1930–31
Adams	37	42	$ 2,986.90	$ 3,118.30
Ashland	18	17	2,955.96	2,772.70
Barron	24	18	1,806.42	2,601.34
Bayfield	6	15	2,244.34	2,420.46
Brown	10	13	1,780.24	1,209.04
Buffalo	5	4	533.12	242.76
Burnett	10	14	866.32	1,392.30
Calumet	6	9	549.78	552.16
Chippewa	39	43	2,339.54	5,611.90
Clark	36	48	3,684.24	4,190.04
Columbia	51	58	3,103.52	4,203.08
Crawford	22	20	2,094.40	2,460.92
Dane	626	683	39,203.56	40,231.51
Dodge	52	61	5,155.08	6,902.00
Door	12	29	2,065.84	3,077.34
Douglas	8	9	916.30	1,961.12
Dunn	6	15	635.46	1,278.06
Eau Claire	5	10	121.38	573.58
Florence		2		435.54
Fond du Lac	51	77	3,960.32	8,053.92
Forest	29	45	2,339.54	4,232.26
Grant	29	24	3,370.08	2,353.82
Green	63	71	4,926.60	5,678.78
Green Lake	10	17	1,141.56	1,404.20
Iowa	16	20	1,463.70	2,330.02
Iron	15	13	2,106.30	1,939.70
Jackson	22	39	3,919.86	3,420.54
Jefferson	45	86	4,117.40	5,792.92
Juneau	38	39	3,379.60	2,720.34
Kenosha	60	102	5,274.08	7,961.10
Kewaunee	3	5	45.22	994.84
La Crosse	33	46	3,722.32	5,433.54
Lafayette	30	34	2,122.96	3,418.78
Langlade	36	30	2,801.26	3,005.94
Lincoln	26	9	3,174.92	1,004.36
Manitowoc	30	18	1,937.32	2,406.18
Marathon	38	41	5,183.64	5,055.12
Marinette	84	90	7,261.38	8,746.50
Marquette	6	10	190.40	568.82
Milwaukee	5	2	749.70	142.80
Monroe	2	17	1,154.30	1,582.70
Oconto	85	73	6,497.40	6,091.04
Oneida	4	18	1,718.36	2,184.84
Outagamie	40	73	5,269.28	6,833.72
Ozaukee	4	8	309.40	673.54
Pepin	1	5		276.08
Pierce	17	10	1,482.74	1,066.24
Polk	22	27	3,282.02	2,989.48
Portage	74	98	8,974.98	7,858.76
Price	18	11	2,891.70	683.06
Racine	59	131	5,174.12	10,155.46
Richland	67	62	5,621.04	4,291.14
Rock	113	167	7,231.30	14,202.00
Rusk	15	11	3,132.08	1,973.02
St. Croix	6	16	694.96	1,328.04
Sauk	95	107	6,454.56	6,456.94
Sawyer	8	4	461.72	161.84
Shawano	19	13	2,218.16	1,456.56
Sheboygan	33	24	3,550.96	1,347.08
Taylor	20	29	1,363.74	2,920.26
Trempealeau	29	15	3,496.22	1,149.54
Vernon	32	39	3,872.26	3,918.20
Vilas	17	24	1,937.32	1,958.74
Walworth	57	68	4,638.62	4,128.12
Washburn	7	14	1,749.30	918.68
Washington	9	11	1,123.36	747.32
Waukesha	51	64	3,758.02	5,466.86
Waupaca	60	77	6,918.66	6,495.02
Waushara	17	24	1,428.00	1,244.74
Winnebago	50	63	4,838.54	8,239.56
Wood	143	166	12,195.60	12,549.32
	2,816	3,397	$249,669.28	$283,246.53

SUPPLEMENTARY REPORT ON "PRIVATE PATIENTS"

By the Special Committee of the State Medical Society of Wisconsin to Study Admissions at the State of Wisconsin General Hospital.

October 14, 1932

Since presentation of its report and findings to the executive committee of the Board of Regents, the special committee of the State Medical Society has devoted further study and investigation of the question of the admittance of private patients to State University Hospitals. This study has included personal and written contacts with educators and the administrative heads of University Hospitals throughout the United States.

The committee is, as stated in its report, earnestly desirous that its criticisms and suggestions be only those which, if made effective, will operate to the distinct advantage of the University as an educational institution, of the hospital as a service institution and to the indivisible and joint interests of both the public and private practitioners of medicine in this state.

We are still firmly of the opinion that our original recommendations with respect to the private pay patients at the state hospital are proper and sound from all view points, a position which has been adopted by the states of Illinois, Nebraska, Colorado, and others. We are, however, also appreciative of the fact that it may not be an easy matter to make sweeping changes in this administrative policy at this particular time.

Our study brings out clearly the unquestionable fact that in many state university hospitals, where private patients have been admitted, there is a definite, decided trend towards the ultimate elimination of this type of admittance. Thus, last year the admittance of private patients to the University of Minnesota State Hospital was but 2½% of the Hospital census. In Michigan, it was less than 2% of the total. In Iowa, the governing board of the State Hospital made an agreement with the Iowa State Medical Society that the admittance of private patients should not be over 5% of the census.

Very clear and forcible expressions of opinions on this problem are coming in ever increasing strength and number from the leaders of our profession.

Thus, Dr. George Crile:

> "It seems to me that it is a sound principle that the responsibility for the treatment of patients who are able to pay, that is to say, who are not indigent patients, must remain with the medical profession. This is the best public policy in the long run. If this is not the case, the profession will not attract a good and competent class of young men to enter the roster of practicing physicians. They must be assured of a fair chance for competition. To the extent that the state interferes with this to that extent in the long run will an inferior type of man select medicine as a career and this will clearly be to the detriment of the public."

Wm. Gerry Morgan, recently President of the American Medical Association, and educator:

> "For a considerable time I have held a settled conviction that state and municipal hospitals should be devoted exclusively to that section of society who are rightly eligible for charity in the treatment of disease. Seems to me something like mixing oil and water to have a hospital essentially developed for the care of the natural wards of the community to also include accommodations for those who are able to pay normal fees for such accommodations. In such cases abuses are bound to creep in, both on the part of the patient as well as of more or less unscrupulous and unthinking practitioners of medicine."

The committee is of the opinion that the eventual solution of the problem, and one which will become generally adopted, is that of paying adequate salaries to certain full-time men with a larger proportion than at present of the instructional staff being comprised of leading, active practitioners who will devote part of their time for little or no salary to the instruction of medical students.

In state university hospital where private patients are still considered acceptable, it is more and more only in the light of a consultation practice. A university hospital staff should in no way act as competitors to the hospitals and profession of the state but, on the other hand, should be of assistance to both. In accepting routine private patients, the university staff is not fulfilling its obligation to the institution. A university full-time staff should be permitted to accept as private patients (if private patients are for the time being acceptable) only a limited percentage of cases and these must be referred by letter from practicing physicians and be cases in which there are special diagnostic or therapeutic problems.

While reaffirming our opinion that it would be to the best interests of the University Medical School to put into effect one or the other of the two recommendations the committee presented in its report as regards the admittance of private patients and remuneration of staff members, the committee, considering the problem at this time from the viewpoint of the Regents, desires to offer, not as a permanent solution but as a temporary experiment the following modification of, or addition to, its original suggestions with the expressed hope that if properly adminstered and given a fair trial it may prove to be in itself an acceptable solution:

Recommendations

1. All private pay patients admitted to the State of Wisconsin General Hospital must be referred to

the Hospital by physicians not on the staff of the institution.

2. Such patients shall be admitted only by a letter or form to be devised specifically requesting such specialized referred consultation or therapeutic care.

3. It is to be distinctly understood, however, that this should not operate to permit admissions for any service other than those of the men who are essentially on full time service at the University Hospital.

4. Members of the teaching faculty who give a part time service are, of course, maintaining Madison offices and Madison hospital connections and may see their referred cases outside the State Hospital.

5. It is understood that strict methods of administration will not permit of admission of patients by other procedure than upon the written request of the attending physician, not connected with the institution, who is desirous of securing this consultation of therapeutic service for the benefit of his patient. For this service the patient will pay the hospital all hospital costs involved and whatever fee is determined upon by the consulting specialist who attends him.

6. We desire and recommend that an agreement be made by the Executive Committee of the Wisconsin State General Hospital with the State Medical Society of Wisconsin that the percentage of private patients thus admitted shall be limited to approximately five per cent (5%) of the hospital census of numbered individual patient admissions.

7. That the hospital full time staff members for whom this service is provided shall restrict their private activities to this service.

8. That the Hospital authorities shall keep an available accessible file in regard to the proper admission of private patients.

9. We believe that in estimating the salary of a full time chief of service who has this privilege of consultation practice and private beds and has the utilization of office space and other facilities that an overhead expense of appreciable amount is saved him and that whatever fixed salary is stipulated, it should be understood to include 15% paid him in this way in lieu of cash. Thus, an incumbent at a salary of $10,000 would receive in cash $8500, and in overhead $1500, making a total of $10,000.

10. It is the opinion of the committee that under this arrangement a thoroughly competent skilled incumbent of one of these positions would, in time, through satisfactory personal demonstration of his superior professional attainments, acquire such a favorable reputation among the active practitioners of the state as to enlist their active and continuing support in the upbuilding of his department for medical educational purposes and this, in the final analysis, should be the paramount function of the institution. It is understood that the acceptance by all such patients of this hospital service automatically makes them available for teaching purposes.

11. It is clearly understood that industrial compensation cases as such are not acceptable unless specifically accompanied by a proper letter from the attending physician.

12. It is clearly understood that non-indigent emergency accident cases brought to the State Hospital shall receive proper first aid and be given a private status which means that the physician in charge of the first aid treatment in such a case may charge whatever fees he deems proper but that as soon it is possible to move the patient without injury to him, he is to be transferred to a private hospital.

13. The committee urges stated semi-annual meetings of the executive committee of the State of Wisconsin General Hospital, with a committee to be appointed by the Council of the State Medical Society of Wisconsin. At such meetings can be had a survey of the work of the institution during the preceding six months with a frank presentation and discussion of whatever problems have arisen assuring that future sympathetic understanding and cooperative endeavor so essential to the proper welfare and progress of the medical school.

MEMBERSHIP, STATE MEDICAL SOCIETY OF WISCONSIN

(As of December 1, 1932)

Adams:
Shapiro, Harry

Adell:
Bemis, Ira M.

Albany:
Allen, W. E.

Algoma:
Foshion, H. V.
Witcpalek, W. W.

Allenton:
Fisher, R. S.

Alma:
Larson, J. A.

Almena:
Arneson, Thomas

Almond:
Meyer, M. W.

Amery:
Cornwall, W. B.

Amherst:
Webster, F. E.

Antigo:
Bloor, E. G.
Donohue, E. J.
Donohue, M. J.
Flatley, M. A.
Lambert, J. W.
McKenna, E. A.
Moore, G. E.
Steffen, L. A.
Wright, J. C.
Zellmer, C. E.

Appleton:
Benton, J. L.
Bolton, E. L.
Brooks, E. H.
Carlson, G. W.
Cooney, E. W.
Dehne, W. O.
Dohearty, F. P.
Gallaher, D. M.
Harrington, Wm. J.
Huberty, F. J.
Landis, R. V.
MacLaren, J. B.
Marshall, V. F.
McCarty, R. T.
McGrath, E. F.
Mielke, E. F.
Millard, A. L.
Mills, N. P.
Neidhold, C. D.
Pardee, C. A.
Rector, A. E.
Reeve, J. S.
Ritchie, G. A.
Ryan, C. E.
Swanton, M. E.

Arcadia:
Comstock, E.
Palmer, J. A.
Weber, F. T.

Argyle:
Williams, W. B.

Ashland:
Dodd, J. M.
Dodd, J. M., Jr.
Grigsby, R. O.
Hertzman, C. O.
Hosmer, M. S.
Prentice, J. W.
Shaw, A. O.
Smiles, C. J.
Tucker, W. J.
Young, M. L.

Athens:
Bachhuber, H. M.
Frick, Lewis

Augusta:
Prill, H. F.

Baldwin:
Kunny, B.
Swenson, G. B.

Balsam Lake:
Meilicke, W. A.

Bangor:
Ruppenthal, K. P.
Ward, M. W.

Baraboo:
Cahoon, Roger
Farnsworth, A. L.
Irwin, H. J.
Kelly, D. M.
McGrath, E.
Snyder, A. F.
Tryon, F. E.

Barron:
Coleman, H. M.
Galloway, A. D.
Post, C. C.
Ruethin, K. A.
Schlomovitz, H. H.

Barton:
Driessel, S. J.

Bayfield:
Shumate, J. K.

Beaver Dam:
Corso, Xavier
Hammond, A. W.
Holtz, H. M.
Hoyer, A. A.
Hoyer, G. H.
O'Hora, C. M.
Riopelle, W. G.
Roberts, R. R.
Rosenheimer, A. M.
Schoen, R. E.
Webb, E. P.

Belmont:
Hubenthal, J. C.

Beloit:
Allen, Jessie P.
Allen, W. J.
Brinckerhoff, F. E.
Brown, E. B.
Burger, H. E.
Crockett, W. W.
Delaney, H. O.
Flarity, T. H.
Fosse, B. O.
Fox, P. A.
Friend, L. J.
Helm, A. C.
Helm, H. M.
Leeson, F. W.
Ottow, A. F.
Raube, H. A.
Schram, C. F. N.
Shearer, H. A.
Smith, C. E.
Thayer, F. A.
Wilson, R. F.
Zwaska, A. B.

Benton:
Leitzell, P. W.

Berlin:
Casper, S. L.
Scott, B. E.
Wiesender, A. J.

Birchwood:
Ainsworth, H. H.

Birnamwood:
Stauff, G. R.

Black Creek:
Laird, J. J.

Black River Falls:
Domine, A. Z.
Krohn, Irwin
Krohn, Robert

Blair:
Richards, R. R.

Blanchardville:
Stuessy, M. F.

Bloomer:
Fortner, W. H.
Hudek, D. F.
Trankle, H. M.

Bloomington:
Baldwin, F. H.
Glasier, M. B.
Harris, C. F.
McLaughlin, H. J.

Blue Mounds:
Bancroft, H. V.

Blue River:
Randall, M. W.

Bonduel:
Terlinden, J. H.

Boscobel:
Betz, J. C.
Freymiller, E. F.
Hayman, C. S.
Spiegelberg, E. H.
Tuffley, F. S.

Brandon:
Shaykett, F. E.
Shepard, E. L.

Brillion:
McComb, I. N.

Brodhead:
Darby, G. S.
Mitchell, E. J.
Ross, M. E.
Taylor, A. R.

Brooklyn:
Gray, Rodney J.

Brownsville:
Fuller, J. D.
Raymond, R. G.

Bruce:
Prentiss, Pearce

Burlington:
Bennett, J. F.
Fulton, W. A.
Newell, F. F.
Prouty, W. A.

Cable:
Clark, Kate

Cambria:
Williams, W. E.

Cambridge:
Amundson, K. K.
Bilstad, G. E.

Campbellsport:
Guenther, O. F.
Hoffmann, L. A.

Casco:
Fencil, Y. J.
Kerscher, E. J.

Cashton:
Cremer, C. H.
Mauel, N. M.

Cassville:
Blackburn, F. E.
Houghton, E. M.
Lechtenberg, E. H.

Cato:
Guttman, Paul
Kelley, J. M.

Cedarburg:
Hurth, O. J.
Katz, H. M.

Cedar Grove:
Van Altena, L. A.
Voskuil, A.

Centuria:
Noyes, G. B.

Chaseburg:
Remer, W. H.

Chetek:
Adams, R. W.

Chilton:
Goggins, J. W.
Knauf, N. J.
Minahan, J. J.

Chippewa Falls:
Beier, A. L.
Ellenson, E. P.
Field, Merton
Hatleberg, C. B.
Henske, W. C.
Kelly, J. A.
McCarty, E. O.
McHugh, F. T.
McRae, J. D.
Schuster, B. L.
Schwartz, R.
Somers, A. J.
Williams, S. E.

Clear Lake:
Campbell, L. A.
Nelson, A. N.

Cleveland:
Reinert, E. N.

Clinton:
Parker, A. S.
Thomas, W. O.

Clintonville:
Finney, W. H.
Miller, E. A.
Murphy, J. H.

Cochrane:
Meili, Emmett A.

Colby:
Christofferson, H. H
Schemmer, A. L.

Coleman:
Graner, L. H.

Colfax:
Cooper, C. A.
Felland, O. M.

Columbus:
Bellack, B. F.
Caldwell, H. M.
Mudroch, J. A.
Poser, E. M.
Schmeling, A. F.
Watson, E. L.

Coon Valley:
Solberg, A. A.

Crandon:
Decker, C. O.
Ison, G. W.

Cross Plains:
Froggatt, W. E. L.

Cuba City:
Bair, F. M.
Donnell, J. E.
Terry, R. E.

Cudahy:
Fine, J. M.
Krueger, B.
Partridge, C. D.
Smith, H. S.

Cumberland:
Babcock, I. G.
Grinde, G. A.
Lund, S. O.
Thompson, R. C.

Dale:
Archer, W. E.

Darien:
O'Brien, H. N.

Darlington:
Orton, Susanne
Quinn, R. B.

Deerfield:
Moe, H. B.

De Forest:
Bertrand, J. H.

Delafield:
Barnes, H. T.

Delavan:
Bachelle, C. V.
Crowe, N. F.
Doughty, J. W.
Jacobson, T. L.
Kenney, H. J.
Wright, C. A.

Denmark:
Hager, F. J.

De Pere:
Kersten, N. M.
Lenfestey, J. P.

DeSoto:
Myrick, A. L.

Dodgeville:
Hagerup, T. A.
Hamilton, D. B.
Morton, H. H.
Reese, William
Walker, H. M.

Dorchester:
Foley, F. P.

Dousman:
Schneider, Hans

Durand:
Schulberg, P. A.

Eagle River:
Oldfield, R. A. A.

East Troy:
Meany, S. G.
Mullen, R. A.
O'Leary, T. J.

Eau Claire:
Anderson, F. G.
Baird, J. C.
Beebe, G. W.
Cook, F. S.
Derge, H. F.
Falstad, C. H.
Flynn, L. H.
Haag, A. F.
Hayes, E. P.
Hayes, E. S.
Henke, Samuel L.
Hoyme, G.
Johnson, Fred
Kinsman, F. C.
LaBreck, F. A.
Manz, Walton R.
Mason, E. L.
Midelfart, H. C. U.
Mitchell, R. E.
Payne, A. L.
Scullard, G.
Seemann, W. O.
Spelbring, P. G.
Stang, H. M.
Stoland, I.
Tanner, J. W.
Tupper, E. E.
Werner, Nels
Werner, R. F.
Ziegler, J. E. B.

Eden:
Hardgrove, J. H.

Edgerton:
Cleary, B. L.
Shearer, A. T.
Shearer, F. E.
Sumner, W. C.

Elcho:
Dailey, P. J.

Eldorado:
Jackson, F. A.

Elkhart Lake:
Rothenmaier, G. L.

Elkhorn:
Herzog, J. V.
Ridgway, E. T.
Sorenson, E. D.

Ellsworth:
Nylander, E. G.

Elmwood:
Breed, A. L.

Elroy:
Ferguson, F. H.
Vogel, C. A.
Vogel, C. C.

Ettrick:
Rogne, C. O.

Evansville:
Guilfoyle, J. P.
Helgesen, E. J.
Osgood, C. W.

Fall Creek:
Zboralski, F. F.

Fall River:
Hunt, F. O.

Fennimore:
Bailey, M. A.
Howell, E. C.
Marsden, T. H.

Fond du Lac:
Alexander, W. S.
Borsack, K. K.
Boyd, G. T.
Devine, H. A.
Devine, J. C.
Finn, W. C.
Florin, A. C.
Folsom, W. H.
Gardner, L.
Gavin, S. E.
Helz, J. W.
Layton, O. M.
Leonard, C. W.
Longley, J. R.
McCabe, P. G.
Meiklejohn, D. V.
Mills, R. G.
Pullen, A. J.
Rehorst, J. J.
Sharpe, H. R.
Sharpe, J. J.
Simon, L. J.
Smith, E. V.
Twohig, D. J.
Twohig, H. E.
Twohig, J. E.
Waldschmidt, W. J.
Walters, D. N.
Wier, J. S.
Wiley, F. S.
Wojta, W. C.
Yockey, J. C.

Footville:
Harvey, J. R.

Forest Jct.:
Wollersheim, P. J.

Forestville:
Hirschboeck, J. G.

Ft. Atkinson:
Bennett, L. J.
Caswell, H. O.
Chase, Estelle S.
Franzel, J. E.
Gruesen, Frank A.
Majerus, P. J.
Morris, R. C.
Venning, J. R.
Young, Will

Fountain City:
Reinhardt, J. P.

Fox Lake:
Elliott, E. S.

Frederic:
Andrews, W. C.
Arveson, R. G.
Diamond, J. A.

Friendship:
Treadwell, G. F.

Galesville:
Alvarez, R. L.
Clauson, C. T.
Jegi, H. A.
Younker, F. T.

Genoa City:
Bill, B. J.

Gillett:
Berg, W. R.

Glenbeulah:
Hansen, John

Glenwood City:
McMahon, A. E.

Glidden:
Gonzalez, L. F.

Grafton:
Balkwill, C. A.

Granton:
Rath, R. R.
Wink, R. H.

Grantsburg:
Johnson, J. E.

Green Bay:
Atkinson, H. S.
Bartran, W. H.
Buchanan, R. C.
Carter, R. M.
Charbonneau, A.
Chloupek, C. J.
Clifford, P. M.
Colignon, J. C.
Comee, William
Cowles, R. L.
Crikelair, F. L.
Decker, W. J.
De Cock, J. L.
DelMarcelle, C. C.
Fuller, M. H.
Gosin, D. F.
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Hagerty, W. T.
Hendrickson, H.
Icks, Karl
Jordon, E. M.
Kelly, W. W.
Killins, W. A.
Kispert, R. W.
Knox, E. S.
Levitas, I. E.
McCarey, A. J.
McNevins, E. S.
Milson, Lewis
Minahan, J. R.
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Mueller, W. E.
Nadeau, E. G.
Oliver, T. J.
Olmsted, A. O.
Quigley, L. D.
Rhode, H. P.
Robb, J. J.
Rose, Felix
Saunders, O. W.
Schmidt, E. S.
Stiennon, O. A.
Tippet, W. P.
Troup, R. L.
Williamson, C. S.
Wolter, H. A.

Green Lake:
Baldwin, G. E.

Greenleaf:
Titel, E. A.

Hales Corners:
Johnson, A. W.
Pierce, D. F.
Wolf, R. C.

Hammond:
Olson, C. A.

Hartford:
Hoffmann, J. G.
Lehmann, F. W.
Loughlin, T. F.

Hartland:
Grover, F. L.
Nixon, H. G. B.

Hayward:
Ballard, J. A.

Hazel Green:
Fillbach, H. E.

Highland:
Erickson, M. T.
Trentzsch, M. W.

Hilbert:
Slaney, A. F.

Hillsboro:
MacKechnie, R. S.

Hixton:
Petzke, E. A.

Hollandale:
McDonald, H. F.

Holmen:
Hanson, L. E.

Horicon:
Karsten, J. H.

Hortonville:
Towne, W. H.

Hudson:
Bradford, E. B.
Livingstone, J. W.
Newton, J. E.

Hustisford:
Goetsch, O. F.
Panetti, P. A.

Independence:
Peterson, C. F.
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Stack, G. F.

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Wilker, W. F.

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Johnson, F. G.

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Schloemer, A. J.

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Klein, Theodore
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Lapp, H. D.
Metcalf, G. S.
Munn, W. A.
Neupert, C. N.
Nuzum, T. O.
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Overton, O. V.
Pember, A. H.
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Stevens, J. V.
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Johnston, W. M.

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Reis, G. W.

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Boyd, C. D.
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Andre, E. F.
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Gascoigne, C. C.
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Lipman, W. H.
Mayfield, A. L.
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Rauch, A. M.
Richards, C. G.
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Ripley, H. M.
Ruffalo, A. F.
Schlapik, A.
Schwartz, G. J.
Sokow, Theodore
Stewart, W. C.
Swarthout, E. F.
Ulrich, C. F.
Windesheim, G.

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Hausmann, N. E.

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Dana, D. B.
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Wochos, F. J.
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Kiel:
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Nauth, D. F.

Kimberly:
Maes, C. G.

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Stein, C. C.

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Callahan, J. L.
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Evans, J. A.
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Gatterdam, P. C.
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Heraty, J. E.
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Jones, W. J.
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MacArthur, D. S.
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McLoone, J. E.
Moran, C. J.
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Reay, G. D.
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Smith, D. S.
Suiter, F. C.
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Townsend, E. H., Jr.
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Wolf, H. E.

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O'Connor, W. F.
Smith, Woodruff

Lake Geneva:
Jeffers, D. H.
Keenan, T. P.
MacDonald, W. H.

Lake Mills:
Eck, G. E.
Engsberg, W. A.
Leicht, Phillip
Peterson, M. G.

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Doolittle, S. W.
Fowler, J. H.
Godfrey, Jos.
Godfrey, R. C.
Kraut, Elgie

Laona:
Clark, J. F. W.
Ovitz, E. G.

Larsen:
Henrichsen, J. A.

Lena:
Rose, J. F.

Little Chute:
Doyle, J. H.

Lodi:
Irwin, G. H.

Loganville:
Jewell, E. L.

Lomira:
Kosanke, F. E.

Lone Rock:
Reynolds, Bertha E.

Luck:
Ries, T. O.

Madison:
Aageson, C. W.
Atwood, David
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Bleckwenn, W. J.
Bowman, F. F.
Boyce, S. R.
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Brown, D. A.
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Bryan, A. W.
Buerki, R. C.
Bunting, C. H.
Burke, C. F.
Burns, R. E.
Caldwell, Ruth
Calvert, Charlotte
Carns, Marie L.
Carter, H. M.
Chorlog, J. I.
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Cline, Frances A.
Cook, C. K.
Cooksey, R. T.
Davis, F. A.
Davis, Helen Pratt
Dean, J. P.
Dean, Joseph
Dimond, W. B.
Ellis, Ivan G.
Elsom, J. C.
Evans, J. S.
Ewell, G. H.
Eyster, J. A. E.
Fauerbach, L.
Fox, Philip R.
Gale, J. W.
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Geist, F. D.
Gonce, J. E., Jr.
Greeley, H. P.
Greene, H. L.
Guilford, H. M.
Gundersen, C. A. S.
Harkins, J. P.
Harper, C. A.
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Harris, J. W.
Head, L. R.
Henika, G. W.
Hill, N. A.
Hyslop, V. B.
Jackson, Arnold
Jackson, J. A., Jr.
Jackson, R. H.
Johnson, H. Curtis
Keck, E. B.
Krehl, W. H.
Kundert, F. W.
Kurtz, C. M.
Lindsay, W. T.
Littig, L. V.
Lorenz, W. F.
Lyght, C. E.
Marsh, H. E.
McGary, Lester
McIntosh, R. L.
Meade, F. S.
Meanwell, W. E.
Middleton, W. S.
Miller, W. J.
Mowry, W. A.
Neff, E. E.
Nelson, O. O.
Nesbit, M. E.
Nesbit, W. M.
Newman, Robt.
Noer, R. J.
Paul, Francis
Paul, Lester W.
Pearson, C. R.
Pessin, S. B.
Pohle, E. A.
Puestow, K. L.
Purcell, H. E.
Quisling, A. A.
Quisling, Sverre
Reese, H. H.
Reineking, W. C.
Ritchie, Gorton
Roach, C. E.
Robbins, J. H.
Schmidt, E. R.
Schneiders, E. F.
Schubert, C. K.
Sevringhaus, E. L.
Sheldon, W. H.
Sisk, I. R.
Sisk, J. N.
Smith, K. W.
Sprague, L. V.
Stebbins, G. G.
Stebbins, W. W.
Stovall, W. D.
Sullivan, A. G.
Sullivan, E. S.
Supernaw, J. S.
Taylor, F. B.
Tenney, H. K.
Thornton, M. J.
Tormey, A. R.
Tormey, T. W.
Van Valzah, R.
Vingom, C. O.
Washburne, Annette C.
Waters, Ralph M.
Wear, J. B.
Weiland, H. P.
Welke, E. G.
Werrell, W. A.
Weston, F. L.
Wheeler, Robert
Winn, H. N.
Wirig, M. H.

Maiden Rock:
Hogan, John

Manawa:
Irvine, R. K.
Irvine, W. J.

Manitowoc:
Aldridge, H. W.
Andrews, M. P.
Ball, E. J.
Barnstein, J. E.
Donohue, W. E.
Gleason, C. M.
Hammond, F. W.
Hammond, R. W.
Hoffman, G. M.
Luhman, F. S.
MacCollum, C. L. R.
Meany, J. E.
Rees, Thomas H.
Schneck, Nathan
Shimek, A. J.
Steckbauer, J. W.
Stueck, A. F.
Teitgen, Arthur
Tompkins, T. B.
Turgasen, F. E.
Wall, Charles E.

Marathon:
Birnbaum, F. A.

Maribel:
May, J. H.

Marinette:
Axtell, L. E.
Berglund, S. A. B.
Bird, M. D.
Boren, C. H.
Boren, J. W.
Duer, G. R.
Jorgenson, H. L.

Lid, T. A.
May, J. V.
Nadeau, A. T.
Redelings, T. J.
Schroeder, H. F.
Shaw, Robert W.

Marion:
Mulvaney, F. M.
Van Schaick, R. E.

Markesan:
Blewett, M. T.
Pfisterer, F. W.

Marshfield:
Boeckmann, F. A.
Copps, L. A.
Deitchman, M. M.
Doege, K. H.
Doege, P. F.
Hipke, Wm.
Juers, R. H.
McCormick, G. L.
Milbee, H. H.
Potter, R. P.
Schwarz, S. G.
Sexton, W. G.
Vedder, H. A.
Vedder, J. B.

Mattoon:
Partridge, O. F.

Mauston:
Gregory, A. T.
Hess, J. S., Jr.
Hess, J. S.

Mayville:
Bachhuber, A. E., Jr.
Bachhuber, A. E., Sr
Bachhuber, F. G.

Mazomanie:
Schultz, I.

McFarland:
MacLachlan, W. G.

Medford:
Nystrum, L. E.
Nystrum, R. C.

Mellen:
Lockhart, C. W.

Melrose:
Lavine, I. H.

Menasha:
Casey, James D.
Corry, F. M.
Forkin, G. E.
Jensen, A. B.
Quackenbush, E. C.

Mendota:
Green, M. K.
Sauthoff, Aug.
Werner, H. C.

Menomonee Falls:
Burkhardt, E. W.
Domann, W. G.

Menomonie:
Blosmo, O. J.
Butler, F. E.
Grannis, I. V.
Halgren, J. A.
Heising, A. F.
Long, D. T.
Steves, B. J.

Mercer:
Rodecker, R. C.

Merrill:
Austria, W. F.
Bayer, W. H.
Hinckley, H. G.
Kelley, F. L.
Lane, Francis C.
Morris, K. A.
Ravn, Bjarne
Ravn, E. O.
Reinhart, D. B.
Winneman, F. A.

Merrillan:
Lowe, J. W.

Middleton:
Allen, C. F.

Milltown:
Nicholson, J. D.

Milton:
Crosley, G. E.

Milton Junction:
Coon, G. E.
Vogel, T. L.

Milwaukee:
Ackermann, Wm.
Adamkiewicz, J. J.
Allen, L. L.
Altenhofen, A. R.
Altman, M.
Ansfield, D. J.
Arnold, F. W.
Augur, Alexander
Ausman, D. C.
Aylward, T. J.
Bach, E. C.
Bach, J. A.
Bach, M. J.
Baer, C. A.
Baranowski, S. A.
Bardenwerper, H. E.
Bardes, Albert
Barnes, J. S.
Barta, E. F.
Barth, G. P.
Baugh, C. W.
Baum, E. L.
Baumgart, C. H.
Baumgarten, S.
Baumle, B. J.
Becker, C. J.
Beckman, Harry
Beebe, C. S.
Belknap, E. L.
Bender, B. I.
Benton, R. W.
Bentzein, E. W.
Bergen, R. D.
Bernhard, L. A.
Bernhart, E. L.
Bickler, E. P.
Biller, S. E.
Birk, B. J.
Blair, J. F.
Blong, Theo. E.
Blount, W. P.
Blumenthal, R. W.
Bodden, A. M.
Boerner, R. W.
Boley, M. H.
Bolger, J. Victor
Borman, M. C.
Bourne, N. Warren
Brah, A. J.
Brehm, P. A.
Brey, P. F.
Brook, J. J.
Brooks, L. M.
Brown, G. V. I.
Brown, S. V. I.
Bruins, Dirk
Brumbaugh, E. V.
Bruns, D. H.
Brussock, W. A.
Burbach, T. H.
Bussewitz, M. A.
Caffrey, A. J.
Cahana, S.
Callan, P. L.
Cannon, H. J.
Carey, E. J.
Carhart, G. A.
Carson, W. J.
Cavaney, J. J.
Chapman, F. M.
Churchill, Bernard P.
Coffey, C. J.
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Conroy, C. F.
Cook, E. F.
Cook, Harold E.
Corcoran, C. J.
Craite, E. J.
Cron, R. S.
Crottier, C. J.
Currer, P. M.
Curtin, A. L.
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Cushing-Lippitt, E.
Dallwig, E. L.
Dallwig, H. C.
Dalton, R. J.
Darling, E. H.
Darling, F. E., Jr.
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Davelaar, G. W.
Davis, Carl Henry
Dearholt, H. E.
Decker, H. G.
deNeveu, A. V.
De Nosaquo, S.
Dickinson, G. H.
Dieterle, J. O.
Differt, C. C.
Doerr, August
Dorr, A. M.
Drew, Frank E.
Drexel, A.
Dries, Joseph
Dudley, L. W.
Dundon, J. R.
Durner, U. J.
Eberbach, C. W.
Echols, C. M.
Edelman, Elsa
Egan, W. J.
Eisenberg, J. J.
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Elconin, D. V.
Enright, John A.
Enzer, Norbert
Epperson, P. S.
Ernst, G. R.
Evans, C. A.
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Everts, E. L.
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Farrell, F. R.
Fechter, F. J.
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Fernan-Nunez, M.
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Fidler, Charles
Fitzgerald, Gilbert
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Fletcher, E. A.
Foerster, H. R.
Foerster, O. H.
Foley, L. J.
Foley, V. G.
Fons, J. W.
Ford, W. B.
Fortier, C. A. H.
Fowle, I. H.
Fox, George W.
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Garvey, J. L.
Gebhard, U. E.
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Grab, J. A.
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Greenthal, R. M.
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Grob, A. R. F.
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Grove, W. E.
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Habeck, E. A. W.
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Hall, R. M.
Hankwitz, P. G.
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Harder, H.
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Haushalter, H. P.
Hawkins, H. M.
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Hitz, H. B.
Hitz, J. B.
Hogue, G. I.
Holbrook, A. T.
Howard, T. J.
Hoyt, Geo. E.
Huber, H. H.
Hughes, J. R.
Hume, W. W.
Huston, John
Jackson, Edw.
Janney, F. R.
Jenner, A. G.
Jenner, J. A.
Jensen, J. M. L.
Jermain, H. F.
Jermain, L. F.
Jermain, W. M.
Jobse, W. P.
Johnson, C. G.
Johnson, F.
Johnson, H. W.
Johnston, T. L.
Joseph, W. A.
Judge, T. A.
Juergens, L. W.
Jurss, C. D.
Jurss, G. J.
Kahn, Joseph
Kastner, A. L.
Kearns, W. M.
Kelly, G. F.
Kettelhut, E. J.
Kilian, A. D.
King, James J.
King, J. M.
Kinsey, Jack L.
Kissinger, C. A.
Kissling, A. C.
Klein, J. T.
Kleinboehl, J. W.
Kleinhans, M. A.
Knudson, A. H.
Koch, M. J.
Koehler, J. P.
Kohn, S. E.
Korthals, F. J.
Kremers, A.
Kretlow, F. A.
Kristjanson, H. T.
Kritter, F. J.
Kriz, G. A.
Kriz-Hettwer, Rose
Krygier, A. A.
Krzysko, S. L.
Kuhn, H. J.
Kuhn, M. J.
Kult, A. J.
Kusterman, A. F.
Lademan, O. E.
Ladewig, A. W.
Ladewig, H. C.
Lahmann, A. H.
Lambeck, F. J.
Langjahr, A. R.
Lawler, T. S.
LeCron, W. L.
Leitch, G. W.
Lettenberger, J.
Lewis, Marian
Lieberman, Benj.
Liefert, W. C.
Light, George
Lillie, O. R.
Lippitt, S. H.
Lobedan, E. T.
Long, C. W.
Lotz, Oscar
Loughlin, D. M.
Love, I. B.
Lynch, D. W. Jr.
MacInnis, F. E.
MacKedon, W. L.
Mackoy, F. W.
MacRae, M. F.
Madison, F. W.
Madison, J. D.
Maercklein, O. W.
Malnekoff, B. J.
Malone, J. Y.
Margoles, F. C.
Markson, S. M.
Marquardt, C. R.
Martens, W. A.
Martin, H. G.
Matthews, J. B.
McBeath, N. E.
McCabe, John
McCann, Edith
McDonald, C. F.
McDonald, R. E.
McGovern, J. J.
McGrath, B. F.
McGuine, H. J.
McKillip, W. J.
McMahon, F. B.
McMahon, H. O.
McMahon, J. P.
McNary, J. F.
McNaughton, W. T.
Megna, Salvatore
Mehigan, D. D.
Melster, W. H.
Mensing, E. H.
Merten, A. N. E.
Merten, P. J.
Messmer, C.
Mieding, A. E.
Miller, E. W.
Miloslavich, E. L.
Miner, H. B.
Mishoff, I. D.
Mitchell, S. R.
Mock, F. C.
Mollinger, S. M.
Montgomery, A.
Morter, C. W.
Morter, R. E.
Mueller, G. F. C.
Mulsow, J. E.
Munkwitz, F. H.
Murphy, F. D.
Murphy, J. A.
Murphy, W. J.
Nebel, Harold
Neilson, G. W.
Nelson, J. D.
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Nichols, W. T.
Niland, P. J.
Nolte, L. G.
Nugent, A. C.
Oakland, H. G.
Oberbreckling, P. E.
Oberembt, B. H.
Oesterlin, E. J.
O'Hara, J. J.
O'Leary, E. B.
Olsen, L. C. J.
Olsen, Maurice
Olson, H. J.
O'Malley, T. S.
O'Malley, W. P.
O'Neill, E. J.
Ozonoff, J. B.
Panetti, E. J.
Paschen, J. G.
Patek, A. J.
Pegram, J. W.
Pendergast, T. J.
Perlson, P. H.
Peterman, M. G.
Pfeffer, E. N.
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Pfeil, R. C.
Pink, J. J.
Plahner, S.
Pleyte, A. A.
Podlasky, H. B.
Popp, Albert
Powers, H. W.
Powers, J. W.
Quick, E. W.
Ragan, W. F.
Raine, Forrester
Rank, R. T.
Rasmussen, H.
Rauchschwalbe, L. E.
Regan, E. D.
Reich, W. F.
Reifenrath, I. B.
Reinke, C. C.
Reuter, M. J.
Reynolds, J. H.
Rheineck, A. F.
Rice, E. M.
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Riehl, F. W.
Roberts, D. W.
Roby, H. S.
Rock, J. N.
Roethke, R. W.
Rogers, E. H.
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Rolfs, T. H.
Rosenberger, A. I.
Rudolf, A. J.
Rueth, J. E.
Ruschaupt, L. F.
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Ryan, E. R.
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Salinko, S. S.
Sander, O. A.
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Savage, G. T.
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Schaefer, A. A.
Schelble, E. J.
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Schiller, L.
Schlaepfer, K.
Schlomovitz, B. H.
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Schlueter, U. A.
Schmidt, H. G.
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Schmit, Felix
Schmit, Louis
Schmitt, G.
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Schneider, C. C.
Schoen, C. M.
Scholter, E. A. W.
Scholz, G. M.
Schoofs, O. P.
Schowalter, R. P.
Schuenzel, L. G. A.
Schulz, G. J.
Schulz, Irwin
Schulz, J. H. A.
Schumacher, H. S.
Schumm, H. C.
Schutte, A. G.
Schwade, E. D.
Schwartz, A. B.
Schweitzer, G. J.
Scollard, J. T.
Scollard, W. J.
Seaman, G. E.
Seeger, S. J.
Seegers, F. W.
Seelman, J. J.
Selle, F. S.
Senn, Ulrich
Sherwood, M. W.
Shimpa, J. F.
Shutkin, Michael
Shutter, H. W.
Siekert, H. P.
Sifton, H. A.
Silbar, S. J.
Sivyer, A. W.
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Smith, J. W.
Smith, L. D.
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Smuckler, R. H.
Spilberg, S.
Spitz, M. M.
Sproule, R. P.
Squier, T. L.
Stack, S. S., Jr.
Stamm, L. P.
Stefanez, J. S.
Stern, Chas. S.
Stiehm, R. H.
Stockinger, R. E.
Stoddard, C. H.
Stratton, F. A.
Studley, F. C.
Studley, Wm. H.
Suhr, A. L.
Sullivan, G. A.
Sure, J. H.
Sweemer, W. M.
Sykes, H. D.
Szlapka, T. L.
Tabachnick, H.
Taugher, V. J.
Taylor, J. Gurney
Tharinger, E. L.
Thill, D. P.
Thompson, E. X.
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Thorndike, W.
Thorstensen, A. H.
Tillson, E. M.
Tisdale, L. C.
Tolan, T. L.
Truitt, J. W.
Tufts, M.
Ulvin, H.
Urdan, B. E.
Van de Erve, W.
Wagner, P. C.

Waldeck, E. A.
Walker, L. J.
Wallschlaeger, G. G.
Walton, W. B.
Warfield, L. M.
Warschauer, B.
Washburn, R. G.
Washburn, W. H.
Wasielewski, F. S.
Webb, H. E.
Weber, A. J.
Wegge, W. F.
Wegmann, N. J.
Weingart, W. F.
Wenn, J. F.
Wenstrand, D. E. W
Westhofen, R. C.
Wetzler, S. H.
Wieder, L. M.
Wiese, M. E. J.
Wiesen, R. P.
Wilets, J. B.
Wilske, C. A.
Witte, D. H.
Witte, W. C. F.
Wolter, S. H.
Wyman, John F.
Yaffe, Aaron
Yanke, A. E.
Yates, J. L.
Zillmer, Helen J.
Zimmermann, C.
Zintek, S. S.
Zivnuska, J. F.
Zmyslony, W. P.
Zuercher, J. C.
Zurheide, H. O.

Mineral Point:
Ludden, H. D.
Ridley, S. R.

Mishicot:
Skwor, C. J.

Monroe:
Baumle, C. E.
Bear, N. E.
Bear, W. G.
Creasy, L. E.
Gnagi, W. B., Jr.
Gnagi, W. B.
Mauermann, J. F.
Moore, L. A.
Ruehlman, D. D.

Monticello:
Blum, O. S.
Ohlsen, M. P.

Montreal:
Ringo, H. F.

Mosinee:
Butler, E. F.

Mount Calvary:
Baasen, J. M.

Mount Horeb:
Buckner, H. M.
Thompson, A. S.

Mukwonago:
Purdy, F. P.

Muscoda:
Ehmer, J. W.
Ruka, E. A.

Neenah:
Brunckhorst, F. O.
Canavan, J. P.
Greenwood, S. D.
Ott, H. A.
Ozanne, I. E.
Pitz, M. N.
Pratt, Geo. N.
Rogers, R. B.
Smith, T. D.
Williamson, G. H.

Neillsville:
Frank, J. H.
Housley, H. W.

Nekoosa:
Backus, O. A.
Pomainville, G. J.

Nelsonville:
Raasoch, H.

New Auburn:
McCormick, H.

Newburg:
Weber, H. F.

New Franken:
Looze, J. A.

New Glarus:
Francois, S. J. A.
McQuillin, E. D.

New Holstein:
Engel, A. C.
Krohn, H. C.

New Lisbon:
Starnes, Brand

New London:
Monsted, J. W., Jr.
Pfeifer, F. J.
Slemmons, T. M.

New Richmond:
Armstrong, J. H.
Epley, O. H.

Newton:
Barnstein, C. H.

Niagara:
De Salvo, Francis
McCormack, Edw.

North Fond du Lac:
Hull, H. H.

North Lake:
Donnelly, F. J.

North Milwaukee:
Pugh, G. J.

Norwalk:
Allen, J. S.

Oconomowoc:
Hassall, J. C.
Loughnan, A. J.
Love, G. R.
Mundt, Raymond
Nammacher, T. H.
Peters, H. A.
Rogers, A. W.
Stemper, I. G.
Wilkinson, D. C.
Wilkinson, J. D.
Wilkinson, J. F.
Wilkinson, M. R.
Wing, W. S.

Oconto:
Armstrong, C. E.
Ouellette, C. J.
Watkins, W. C.

Oconto Falls:
Goggins,R. J.
Krahn, G. W.

Omro:
Fleury, F. D.
Schoenbechler, L. J.

Ontario:
Devine, G. C.

Oostburg:
Guy, Emmett F.

Oregon:
O'Brien, J. M.

Orfordville:
Belting, G. W.

Osceola:
Gleason, W. A.
Simenstad, L. O.

Oshkosh:
Andrews, Neil, Jr.
Beglinger, H. F.
Bickel, E. F.
Bitter, R. H.
Clark, Burton, Jr.
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Combs, C. J.
Conley, J. M.
Connell, F. Gregory
Danforth, Q. H.
Ebert, R. O.
Haines, M. C.
Haubrick, H. J.
Helmes, L. O.
Hogan, J. M.
Hugo, D. G.
Kleinschmidt, H. W.
Koehler, A. G.
Linn, W. N.
Lockhart, J. W.
Lynch, G. V.
Meilicke, C. A.
Meusel, H. H.
Ozanne, J. T.
Peake, E. P.
Pfefferkorn, E. B.
Romberg, H. A
Schein, J. E.
Schneider, John F.
Smith, Leonard M.
Smith, William M.
Steele, G. A.
Stein, J. F.
Sutherland, J.
Wagner, W. A.
Wheeler, W. P.
Williams, E. B.

Osseo:
Knutson, O.
Leasum, R. N.

Owen:
Dike, B. H.

Pardeeville:
Chandler, J.
Gillette, H. E.

Park Falls:
Leahy, J. D.
Riley, E. A.

Pepin:
Belitz, A. E.
Brookie, R. W.

Peshtigo:
Haasl, H. W.

Pewaukee:
Egloff, L. W.

Phillips:
Norviel, H. B.
Van Hecke, D. S.

Pittsville:
Beyer, Hart

Plainfield:
Andrae, R. W.

Platteville:
Andrew, C. H.
Cunningham, Wilson
Schuldt, C. M.

Plymouth:
Deicher, H. F.
Dietsch, Leland C.
Meyer, R. C.
Mueller, J. F.
Radloff, A. C.
Sieker, A. W.

Portage:
Batty, A. J.
Bentley, J. E.
Henney, C. W.
MacGregor, J. W.
Meacher, B. C.
Schloemilch, A.
Snyder, K. A.
Taylor, W. A.
Tierney, E. F.

Port Washington:
Barr, Arnold
Drissen, W. H.

Poynette:
Focke, W. J.

Prairie du Chien:
Armstrong, C. A.
Kane, J. J.
Pinkerton, W. T.
Satter, O. E.
Shapiro, H. L.

Prentice:
MacKinnon, G. E.

Prescott:
Dill, G. M.
Jones, L. E.

Pulaski:
Dupont, A. J.

Racine:
Albino, J. M.
Anderson, J.
Brehm, H. G.
Brehm, H. J.
Brehm, T. G.
Buckley, W. E.
Chamness, G. C.
Christensen, F. C.
Collins, W. P.
Constantine, C. E.
Corr, J. T.
Docter, John
Fazen, L. E.
Hahn, C. K.
Hahn, Paul R.
Hansen, L. B.
Hanson, W. C.
Hemmingsen, T. C.
Henken, J. F.
Hogan, J. H.
Holmes, B. H.
Jamieson, G. H.
Jamieson, R. D.
Jones, Susan
Keland, H. B.
Kurten, R. M.
Lindner, A. M.
Marek, F. B.
Meachem, J. G.
Miller, H. C.
Nelson, A. L.
Northey, T. McK.
Peterson, R. O.
Pfeifer, E. C.
Pfeiffer, A. S.

Pfeiffer, O. W.
Pope, F. W.
Ross, G. L.
Roth, W. C.
Schacht, R. J.
Schaefer, C. O.
Schneller, E. J.
Schnetz, L. N.
Thackeray, R. C.
Thompson, I. F.
Tompach, E. L.
Von Buddenbrock, E.
Wagner, N. B.
Walters, H. G.
Wier, F. A.
Williams, A. J.

Randolph:
Costello, W. H.
Jones, A. W.

Random Lake
Malloy, T. E.

Redgranite:
Dietrich, C.

Reedsburg:
Booher, J. S.
Edwards, A.

Reedsville:
Cary, E. C.

Rhinelander:
Bump, W. S.
Frisbie, R. L.
Packard, C. D.
Richards, C. A.
Schiek, I. E.
Weed, L. G.

Rice Lake:
Charron, T. A.
Dawson, D. L.
Knapp, E. J.
Rydell, W.
Sattre, O. M.
Wallis, J. H.
White, A. S.
Wiger, H. C.

Richfield:
Bossard, C.

Richland Center:
Benson, G. H.
Coumbe, W. R.
Davis, L. C.
Dull, C. F.
Edwards, W. C.
McCarthy, H. C.
Pippin, B. I.

Rio:
Maas, W. C.
Pease, W. A.

Ripon:
Cole, D. F.
Eisele, P. L.
Johnson, J. M.
O'Neal, Orvil
Senn, C. U.

River Falls:
Cairns, Rolla
Davee, Chalmer
Dawson, C. A.
Gendron, A. E.
McJilton, C. E. J.

Rockbridge:
Hines, L. L.

St. Cloud:
Werner, C. F.

St. Croix Falls:
Caldwell, H. C.
Riegel, J. A.

Salem:
Fletcher, W. T.

Sauk City:
Hudson, Leo

Seymour:
Hittner, V. J.
Holz, A. P.

Sharon:
De Wire, M. V.
Hoffman, E.
Treat, C. R.

Shawano:
Cantwell, A. A.
Cantwell, R. C.
Peterson, L. W.
Schroeder, E. L.
Stubenvoll, C. E.

Sheboygan:
De Swarte, L. J.
Eigenberger, F.
Fiedler, Otho A.
Ford, W. A.
Genter, A. E.
Gunther, O. T.
Gunther, T. J.
Gunther, W. H.
Gutsch, O. J.
Heiden, H. H.
Hildebrand, G. J.
Juckem, G. J.
Junck, J. A.
Knauf, A. J.
Knauf, G. E.
Kraft, Sigfried
Nause, F. A.
Neumann, W. H.
Ryan, E. S.
Sonnenburg, C. N.
Sonnenburg, W. M.
Squire, C. A.
Stannard, G. H.
Tasche, C. T.
Tasche, J. C.
Tasche, Leslie W.
Van Zanten, Wesley
Van Zanten, Wm.
Weber, C. J.
Zaegel, R. L.
Zohlen, J. P.

Sheboygan Falls:
Bassuener, R. O.
Blekking, J. H.
Leighton, F. A.
Pfeiler, A. G.

Shell Lake:
Hering, E. R.

Shiocton:
LaCroix, G. M.

Shullsburg:
Ennis, S. A. J.
Gratiot, M. P.
Hoesley, H. F.

Silver Lake:
Becker, B. A.

Soldiers Grove:
McDowell, A. J.

Solon Springs:
Wilcox, A. G.

South Milwaukee:
Grimm, J. J.
O'Brien, George M.
Sanford, J. A.
Schlossmann, B.
Sickles, W. A.

Sparta:
Beebe, C. D.
Beebe, C. M.
Beebe, S. D.
Phalen, C. S.
Scantleton, J. M.
Williams, H. H.

Spencer:
Callahan, H. T.

Spooner:
Lemmer, G. N.

Spring Green:
Nee, Frank
Wahl, C. M.

Spring Valley:
Conway, H. P.

Stanley:
Graber, R. E.

Spring Valley:

Star Prairie:
Perrin, H. E.

Statesan:
Thompson, R. D.

Steuben:
Dillman, A. E.

Stevens Point:
Benn, H. P.
Coon, H. M.
Coon, J. W.
Cowan, W. F.
Crosby, E. P.
Diamond, F. J.
Dunn, A. G.
Gregory, W. W.
Kidder, E. E.
Krembs, F. R.
Marrs, F. A.
Rice, D. S.
Rice, R. W.
Sinaiko, A. A.
Southwick, F. A.
von Neupert, C.
Weller, E. A.
Wisiol, Erich

Stoughton:
Keenan, H. A.
Newlove, F. E.
Schoenbeck, R. F.
Smedal, A. T.

Stratford:
Kroeplin, F. C.

Sturgeon Bay:
Dorchester, D. E.
Egeland, G. R.

Sturtevant:
Peehn, F. G.

Sullivan:
Notbohm, W. R.

Sun Prairie:
McCabe, James M.
Peterson, L. W.

Superior:
Baird, John
Broghammer, F. J.
Charbonneau, E.
Christiansen, C. H.
Conklin, G. H.
Ekblad, V. E.
Giesen, C. W.
Goodfellow, J. R.
Ground, W. E.
Hathaway, G. J.
Hovde, A. G.
McGill, J. W.
McGill, P. G.
Meyers, J. M.
Myers, E. A.
O'Leary, T. J.
Orchard, H. J.
Rollefson, C. J.
Sarazin, F. C.
Saunders, Geo.
Schnell, W. H.
Searle, D. R.
Sincock, H. A.
Smith, R. C.
Wall, M. H.
Zwickey, W. H.

Suring:
Dougherty, J. S.

Sussex:
Lawler, G. W.
Van Valin, E. C.

Taylor:
Crane, M. C.

Theresa:
Langenfeld, P. F.

Thiensville:
Carthaus, A. H. C.
Rock, J. W.
Scholz, H. F.

Thorp:
Kulig, A. H.
Neis, F. P.

Tigerton:
Gates, A. J.

Tomah:
Bell, A. R.
Scheurich, L. G.
Sheehy, T. J.
Winter, A. E.

Tomahawk:
Baker, G. R.
Baker, R. G.
McCormick, W. C.

Turtle Lake:
Tanner, G. F.

Two Rivers:
Farrell, A. M.
Moriarty, L. J.
Zlatnik, A. P.

Union Grove:
Atherton, C. C.
McCracken, R. W.

Valders:
Rauch, W. A.

Verona:
Sharpe, H. A.

Vesper:
Whitehorn, E. E.

Viola:
Parke, George

Viroqua:
Lauder, C. E.
Ludden, R. H.
Trowbridge, C. H.
Trowbridge, W. M.

Waldo:
Richards, C. B.

Walworth:
Coon, W. W.
Richardson, W. C.

Washburn:
Axley, A. A.

Waterford:
Malone, F. A.

Waterloo:
Allen, S. C.
Dennis, J. F.
Fiebiger, G. J.

Watertown:
Abelman, T. C. H.
Becker, W. C.
Bowen, E. W.
Bowen, H. P.
Dierker, O. F.
Nickels, A. C.
Nowack, L. H.
Waite, W. S.
Wallner, A.
Zimmermann, F. H.

Waukesha:
Aplin, F. W.
Campbell, W. B.
Caples, B. M.
Christiansen, J.
Davies, R. E.
Edmondson C. C.
Fain, S. C.
Harkness, G.
Hodgson, A. J.
Klinger, George
Kovacs, Arthur
Nicely, W. E.
Noble, J. B.
Oatway, W. H.
Peterson, G. E.
Pretts, W. W.
Prince, L. H.
Rhea, C. W.
Tibbitts, U. J.
Waite, R. A.
Werra, M. J.
Williams, A. J.
Wood. C. A.
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